

SECTION III

PERFORMANCE GOALS AND ACTION PLAN

TO IMPROVE THE SERVICE SYSTEM

Adult Mental Health Plan

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ADULT PLAN

CRITERION #1: Comprehensive Community – Based Mental Health Service System

Mental health transformation efforts and activities in the state are described within the narrative for each criterion and then referenced to the specific goal(s) in the New Freedom Commission (NFC) Reports.

AVAILABLE SYSTEMS OF TREATMENT, REHABILITATION, AND SUPPORT SERVICES

Services Available

At this time, community-based services in the fee-for-service benefits package include:

- Psychiatric hospitals
- Psychiatric units of acute care general hospitals
- Residential treatment centers (RTCs) (children and adolescents only)
- Psychiatric day treatment (also called partial hospitalization)
- Outpatient mental health clinics (many of which provide school-based and after-school treatment programs)
- Psychiatric rehabilitation programs (PRPs)
- Residential rehabilitation programs (RRPs)
- Case Management
- Mobile treatment services (MTS)
- Supported living programs
- Supported employment (SE) and vocational services
- Respite care
- Residential crisis services
- Therapeutic behavioral aides
- Mental health related laboratory services

Finally, MHA also provides funds through contracts to programs that offer specialized services (e.g., mobile crisis) that do not fit the fee-for-service model. These programs are eligible to apply for funds, as are consumer support programs such as peer support programs, family support groups, consumer-run businesses, and protection and advocacy services (at least two of which are peer-run. In FY 2010, MHA worked with Medicaid to amend the Medicaid State Plan and regulations for case management. On September 1, 2009, MHA in collaboration with the CSAs and the ASO implemented and monitored the transition from contracted case management services to the fee-for-service system (FFS) for Medicaid recipients and uninsured individuals.

Any provider who meets appropriate licensing, certification, accreditation, or other applicable standards is eligible to become a provider in the fee-for-service system. Eligible providers include facilities, programs, and individual practitioners. Individual practitioners include physicians, psychologists, nurse psychotherapists, clinical social

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workers, occupational therapists, and licensed clinical professional counselors who are allowed to practice independently under their Practice Acts. This increase in the provider community offers consumers an expanded choice of providers.

In addition, services such as those for individuals who are deaf or hard of hearing, involved in the criminal justice system, or have co-occurring (mental illness and substance abuse) issues are available. Examples for these specific populations are depicted below:

Services for the Deaf and Hard of Hearing. The Director of MHA's Office of Special Needs Populations, in collaboration with CSAs, works with community-based programs, the state hospital and the Governor's Office of the Deaf & Hard of Hearing (ODHH) Advisory Council to coordinate community and inpatient services for persons who have a serious mental illness (SMI) and are deaf or hard of hearing. MHA currently operates a separate unit at a State hospital for deaf consumers in need of hospitalization. The unit provides full accommodations for deaf consumers and employs a full complement of mental health professionals who are fluent in American Sign Language. MHA also provides funding to CSAs to contract with providers in order for deaf consumers to access outpatient treatment, psychiatric rehabilitation services, case management, and residential rehabilitation services which have interpreters and/or staff fluent in American Sign Language. Additionally, limited outpatient clinic and residential rehabilitation services are available to individuals who have a SMI who are deaf or hard of hearing through the fee-for-service system.

In FY 2010, MHA participated on a behavioral health subcommittee, comprised of representatives from MHA, the Alcohol and Drug Abuse Administration, the Developmental Disabilities Administration, behavioral health providers, the Maryland State Department of Education, consumers, family members, and advocates. The behavioral health subcommittee drafted minimum criteria for providing behavioral health care for Marylanders who are deaf and hard of hearing for DHMH. Additionally, the subcommittee drafted recommendations to MHA's ASO regarding standards for public mental health providers certifying proficiency and cultural competency in serving consumers who are deaf and hard of hearing. MHA also served as the Department of Health and Mental Hygiene's representative on the Maryland Advisory Council for Individuals who are Deaf and Hard of Hearing. MHA continued to work with the Office of Deaf and Hard of Hearing (ODHH) Advisory Council to develop strategies to improve access to outpatient treatment and improving the competencies of outpatient providers working with consumers who are deaf and hard of hearing. In May 2010, MHA hosted a cultural sensitivity and awareness training for behavioral health providers, CSAs, consumers, and advocates on understanding issues faced by consumers who are deaf and hard of hearing, and will offer future trainings in collaboration with the Governor's Office of Deaf and Hard of Hearing to increase awareness and understanding of providers in working with individuals who are deaf and hard of hearing and have a serious mental illness. Additionally, consumers who are deaf and hard of hearing actively participate in the MHA annual State Plan Development Stakeholders meeting.

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Services for Individuals in the Criminal Justice System. In 1995, the U.S. Department of Housing and Urban Development (HUD) awarded MHA a five-year, \$5.5 million Shelter Plus Care grant to provide housing for individuals who are homeless with serious mental illnesses (with or without accompanying substance abuse) and their dependents, who are being released from the detention center or are in the community on the intensive caseloads of parole and probation. Last year, the FY 2010 Shelter Plus Care Housing grant was renewed for \$3,820,578 for 22 Shelter Plus Care renewal grants. For FY 2011, MHA was awarded funding in the total amount of \$4,529,532 for the Shelter Plus Care renewal grants. The renewal grant award was increased largely due to increases in the Fair Market Rental Values, increases in the number of units funded by HUD, and the renewal of all five-year grants. Currently, MHA is serving a total of 599 persons, 137 single individuals with mental illness, 165 families with 283 children and 14 other family members through all of the Shelter Plus Care grant programs.

The Maryland Community Criminal Justice Treatment Program (MCCJTP), with total state funds of \$1.9 million, supports specific programs targeted at adults 18 years of age and older with SMI in detention centers. The development and delivery of care extended to these individuals is rooted in two key principles: 1) create a continuum of care by providing a variety of services by mental health professionals working within the jail and in the community; and 2) develop a local advisory board to conduct a needs assessment particular to the jurisdiction. In FY 2010 the MCCJTP operated in 22 Maryland counties and received an estimated total of 6,800 referrals from which an estimated 5,800 received treatment. Program reports over 4,000 hours of psychiatric services, nearly 20,000 hours of combined individual and group psychotherapy, and more than 15,000 hours of case management. While MCCJTP is unable to track recidivism from county to county until information technology is in place, the current recidivism rate is estimated to be between five percent (5%) and ten percent (10%).

In addition to working with the counties, MHA continued to partner with Baltimore City to provide post-booking aftercare planning through the Forensic Aftercare Services Team (FAST). In FY 2009 FAST screened and conducted a face to face evaluation of more than 1,000 individuals for program appropriateness and monitored 41 individuals in the community as part of a court ordered release plan.

Maryland's efforts to address the issues of individuals with mental illnesses in the criminal justice system were also driven by legislative action which led to the establishment of various workgroups. In FY 2007, a "think-tank" was established in response to House Bill (HB) 990/Senate Bill (SB) 960. The group was charged with exploring issues targeted at "breaking the cycle of re-arrest and re-incarceration" for individuals with mental illnesses. Now formed as the Mental Health and Criminal Justice Partnership (MHCJP), it continues to work with corrections, mental health, substance abuse, consumer and advocacy groups, and other key stakeholders. Their mission is to identify services that aid in reducing recidivism to detention centers.

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The Mental Health Transformation Office (MHTO) continues to move forward in supporting efforts that will create a continuum of care for persons with mental illnesses who also have involvement with the criminal justice system. House Bill (HB) 281 required that a work group be developed to address these concerns. The HB 281 Workgroup included representatives from the Department of Public Safety and Correctional Services (DPSCS), Mental Hygiene Administration (MHA), Department of Health and Mental Hygiene (DHMH), Department of Human Resources (DHR), and mental health, legal, correctional, social service, and mental health consumer and advocacy communities. Also, the Maryland Advisory Council on Mental Hygiene/PL 102-321 Planning Council, in collaboration with the Mental Health & Criminal Justice Partnership and the Interagency Forensic Services Committee, continued to promote the development of services including early intervention, diversion, and re-entry for individuals with mental illnesses who encounter the criminal justice system. Additionally, MHA submitted a report detailing its plan to enter into memoranda of understanding with local detention centers to establish a data sharing initiative.

In FY 2009, MHA's Office of Forensic Services in collaboration with the Mental Health & Criminal Justice Partnership continued to provide support for services to individuals in the criminal justice, judicial and PMHS regarding community psychiatric services for inmates with mental illnesses upon release and the development of diversion services. [NFC 2]

MHA also provides \$440,000 in State general funds for the Trauma, Addictions, Mental Health, and Recovery (T.A.M.A.R.) Project which provides treatment for incarcerated men and women who have histories of trauma and have been diagnosed with a mental illness and/or co-occurring substance abuse disorder. The project is available in eight county detention centers; Anne Arundel, Baltimore, Caroline, Dorchester, Frederick, Garrett, Prince George's, Washington Counties and at Springfield Hospital Center. TAMAR was expected to serve more than 525 individuals in FY 2010 with a combination of services to include individual and group counseling, grief counseling, and case management. To date, 85 percent of treated individuals were identified with a co-occurring substance abuse disorder. In addition, the project is integrated with HIV/AIDS risk awareness and prevention strategies. TAMAR was recognized in July 2008, with the H.O.P.E. award from the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Center for Trauma Informed Care for the state's leadership in providing trauma-informed care and the TAMAR Program. [NFC 5]

In 2007, Maryland-produced a documentary film, "Behind Closed Doors," which highlights the impact of trauma on the lives of four women. Their compelling stories of recovery offer hope and demonstrate the potential for trauma-informed, innovative programming. This nationally recognized film was produced by the Maryland Disability Law Center with support provided through Maryland's Alternatives to Seclusion and Restraint Project, funded by a SAMHSA grant. It was nominated by SAMHSA for the Voice Award. The National Technical Assistance Center has incorporated the film into their national and international trauma-informed care trainings for publicly funded institutions. A follow up documentary, "Healing Neen," was produced with partial

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funding from the State and directed by the Maryland Disability Law Center. Premiering in 2010, the film featured the life story of Tonier Cain (one of the women featured in the original documentary) and is also used as a national and state training tool.

The majority of the women with co-occurring disorders in the criminal justice system have children and a smaller population is pregnant while incarcerated. MHA was instrumental in developing and implementing a program for eligible pregnant women who were incarcerated or at risk of incarceration in local detention centers and the Maryland Correctional Institute for Women (MCIW).

The Chrysalis House Healthy Start Program, formerly known as TAMAR's Children, is a collaborative effort with the Department of Public Safety and Correctional Services, the Administrative Office of the Courts, the Alcohol and Drug Abuse Administration, the Family Health Administration, Baltimore Mental Health Systems, Inc. and the Archdiocese of Baltimore. This program, funded through state general funds, consists of a 16-bed diagnostic and transitional facility for pregnant and post-partum women and their babies. Pregnant women are referred by the court, the state, Defense Attorney, or DHMH. A comprehensive assessment is conducted by a licensed clinician and an individualized treatment plan is developed between each woman and the treatment team. After the newborn's birth, the mother and baby remain in the residential facility and receive a comprehensive array of services. Services include medical care through contract with a health care organization, mental health treatment which includes trauma and attachment-based treatment interventions, substance abuse treatment and co-occurring treatment services, legal services, parenting and childcare services which includes involvement from the Healthy Start and Family Tree Programs, housing, after-hours residential support, health education, and other support services.

Between, July 2007 and February 2010, a total of 39 women have been admitted to the program and over 20 babies have been born during this period. Ninety percent (90%) of those admitted are on probation; 64% are known to have both mental health and substance abuse issues and 87% have a history of trauma.

There were significant improvements reported in mental health, overall health, cognitive functioning and day to day functioning. There were significant reductions reported in criminal behavior, including the use of illegal drugs and receiving money from illegal sources. There was an increase in the amount of money received from benefits such as Temporary Assistance for Needy Families (TANF) and food stamps. There was an increase in enrollment in training/school programs, although there was a small decrease in the numbers employed.

Services for Individuals with Mental Illness and Substance Abuse. Over the past year, the Mental Hygiene Administration (MHA) has worked toward the implementation of a work plan designed to increase the number of programs that are dual diagnosis capable (DDC). Six county jurisdictions which have chosen to adopt the implementation of the Comprehensive, Continuous Integrated System of Care model

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(CCISC) are in various stages of development. Assertive Community Treatment (ACT) teams are receiving training on dealing with substance abuse to improve the Dual Diagnosis Capability of each of the 10 ACT teams, on an individualized basis.

MHA, in collaboration with the Alcohol and Drug Abuse (ADAA) and the Developmental Disabilities Administrations (DDA), is co-sponsoring a Supervisors' Academy. This Academy began in the spring of 2010, and will continue for a year. Participants are from all three administrations. Utilizing a Training of Trainers format, participants are learning the training models from a curriculum developed by Southern Maine, and adapted to include developmental disabilities and traumatic brain injury, as well as Maryland-specific information.

MHA has also sponsored regional workshops on screening and assessment for substance abuse, to encourage integrated treatment. These trainings are also open to the other two administrations mentioned above. In the coming year, each Core Service Agency (CSA) will have individual consultation to engage in a discussion about the best way to achieve dual diagnosis capability for their providers. CSA's are located in Baltimore City and every county except Midshore, which has 5 counties. Somerset and Wicomico counties are now working together in one CSA. CSA's help manage the public mental health system in each jurisdiction. The discussion will include how to ensure integrated care of the co-occurring population.

Under the direction of the Deputy Secretary for Behavioral Health and Disabilities, MHA now works more closely with ADAA and DDA. Meetings are held on a regular basis to discuss training, health disparities and data. The Office of the Deputy Secretary is working toward the goal of expanding the development of a system of integrated services including substance abuse, mental health, developmental disabilities and somatic care. The Office is also targeting forensic issues, the goal of addressing systems change, and implementing treatment and supports.

An important development in the provision of co-occurring services to individuals with mental illnesses and substance disorders was the Substance Abuse and Mental Health Services Administration (SAMHSA) grant awarded to provide substance abuse and mental health services for people who are homeless. The grant enables communities to expand and strengthen their treatment services for individuals who are homeless with substance abuse disorders, mental illness, or co-occurring (substance abuse disorders and mental illness). In Maryland, People Encouraging People, long a leader in mental health services and outreach to the homeless in Baltimore City, was awarded \$400,000 per year for five years to create a comprehensive dual-diagnosis treatment program for persons who are homeless and have substance abuse and mental health problems.

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Housing for Adults with Psychiatric Disabilities

Housing that is affordable, accessible, and integrated in the community is a major factor in enhancing the recovery of persons with serious mental illnesses (SMI). Toward this end, MHA actively collaborates with the Maryland Department of Housing and Community Development (DHCD), federal Housing and Urban Development (HUD), county housing authorities, local housing coalitions, and county agencies as well as non-profit developers and mental health providers. These partnerships promote access to housing development that is affordable with assistance from specialized government-supported housing opportunities. DHCD is represented on the Joint Maryland Advisory Council on Mental Hygiene/PL 102-321 Planning Council.

To assure that consumers of mental health services have a continuum of housing and other residential options, MHA encourages the CSAs to work with local housing authorities and housing developers to develop affordable and safe housing in their regions. This has resulted in extensive partnerships to provide consumers with affordable housing and rental subsidies along with accompanying support services as needed and requested by the consumer. Providers of residential rehabilitation services with CSA support have submitted applications for HUD 811 that comes with designated Flexible Housing Choice Vouchers. However, due to changes in the federal budget priorities and the increase cost of all housing, access to new housing vouchers for individuals with disabilities has been limited. Currently, MHA is collaborating with local public housing authorities (PHAs) and other organizations to respond to the Federal Non-Elderly Persons with Disabilities NOFA to provide new vouchers. In addition, MHA will continue to work with CSAs to expand mainstream rental opportunities that enhance affordable housing options for individuals with SMI. At the provider level, many mental health providers have also helped consumers successfully pursue rental assistance for Supported Housing Initiatives, the Bridge Subsidy Pilot Program, Housing Choice Vouchers and other services. The Bridge Subsidy Pilot Program began in January 2006 in several counties around the state including the eight Eastern Shore and two Western Maryland counties. The Bridge Subsidy Pilot Program is closed and not accepting new referrals due to a lack of sustained funding. The program assisted in providing rental subsidies to 111 individuals of which 72 consumers with mental illness have or will transition to a permanent voucher. Overall, from 2009 to present, 16 individuals have moved from residential rehabilitation programs (RRPs) to independent housing within this pilot program.

Additionally, MHA has encouraged and provided some financial incentives to establish non-profit housing development entities. Many of these entities, as well as mental health provider organizations, have developed affordable housing through community bond grants through Maryland's DHMH's Administration-Sponsored Capital Program. MHA has identified housing as its priority for receipt of these bond monies. Several of this year's Capital Program awards addressed this priority. [NFC 2]

MHA continues to fund Main Street Housing, Inc., a consumer-operated project, whose mission is to enable consumers with limited income to live in the least restrictive setting. Main Street Housing, a subsidiary non-profit corporation of On Our Own of

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Maryland, is dedicated to providing safe and affordable housing to persons with psychiatric disabilities. Main Street Housing is now designated as a Community Housing Development Organization (CHDO). Under the MHT-SIG grant, they are developing a database system that will track tenant outcomes. The system will focus on understanding the relationship between stable, permanent housing and the stability of the tenants. Also staff from property management can better pinpoint when a tenant may need a referral to supportive services before housing options are in jeopardy.

Main Street is located in the following counties: Allegany, Washington, Carroll, Frederick, Howard, Harford, Queen Anne's, Talbot, Caroline and Dorchester counties. The program supports 17 buildings with 30 units and 64 tenant slots of which there are 5 additional participants who are children living with parents. Total number served is 59.

Other partnerships with mainstream housing developers, Community Housing Development Organizations (CHDOs), and other non-profit housing agencies have also produced a steady growth in affordable housing:

Examples include:

- Baltimore City: Community Housing Associates, Inc. (CHA), a private, non-profit housing development agency, provides low-cost housing for individuals with psychiatric disabilities through an innovative combination of grants, loans, and tax incentive programs. CHA now owns a total of 83 units that provide housing for 193 individuals and 62 families. In addition, CHA administers 161 Shelter Plus Care certificates. CHA works with the Baltimore Mental Health Systems (BMHS) and mental health providers to provide case management and other supports to help consumers remain in their own homes.
- Anne Arundel County: Supported Housing Developers, Inc. (SHD), a non-profit agency, currently operates 34 units/residences providing housing with the potential of serving 64 individuals (currently housing 58 individuals). SHD maintains a landlord – tenant relationship and encourages occupants to exercise choice about participation in mental health programs. Psychiatric rehabilitation programs (PRPs) in the county provide, to the extent needed, support services to the consumers.
- Montgomery County: Housing Unlimited, Inc. (HUI), a CHDO formed by the Montgomery County chapter of the Alliance on Mental Illness, maintains a landlord-tenant relationship with each resident, who may elect to receive mental health services from a local provider of his or her choice. Currently, 42 residences provide housing to 126 tenants (adults) in scattered-site housing throughout the county.
- MOSAIC, Inc. and its housing subsidiary, ReChodo, Inc., provide housing for 33 individuals in 33 residences. Services are provided in suburban Baltimore County (23), Baltimore City (5) and Carroll County (5).

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- Turning Point in Washington County has 12 one-bedroom apartments and 7 one-bedroom apartments leased to 19 tenants. There are 5 one-bedroom apartments serving 5 consumers receiving Assertive Community Treatment. Tenants have the option to access mental health services through a variety of community resources.
- Way Station in Frederick County supports 12 consumers in regular Supported Housing and another 17 consumers from the ACT program. Some of these units provide housing for multiple individuals in one-bedroom.
- Way Station in Howard County provides five supported housing units in Howard County that serve five tenants. Individuals in each county can choose to access mental health services through a variety of community resources.

MHA in collaboration with the MHTO contracted and received a report from the Technical Assistance Collaborative, Inc., (TAC), a Boston consulting agency to obtain an assessment of current housing programs, funding resources and recommendations for inclusion in a housing plan for future improvements. Recommendations include expansion of housing opportunities for priority consumer groups, including individuals with mental illness or with co-occurring mental illness and substance abuse disorders. The plan will maximize funding (including DHMH's Administration-Sponsored Capital Program grant community bond) from federal, state and local funding sources to expand housing opportunities for individuals with mental illnesses. The recommendations will integrate MHA's plans with HUD, DHCD and DHMH Office of Capital Planning demonstrations. Additionally, DHMH, DHCD and the Department of Disability (DOD), jointly developed a strategic plan for the development of affordable independent housing for persons with disabilities, specifically those with SMI and those with a developmental disability. The plan includes recommendations and strategies to maximize utilization of existing resources, efforts to generate rent subsidies and approaches to overcome barriers to development of housing.

MHA has long funded residential rehabilitation programs (RRPs), which are programs that offer residential services to persons with SMI in need of intensive services and supports to eventually integrate into the community. Expansion of RRP beds in the last several years has been targeted to specific initiatives. Currently there are 2482 RRP beds in the system. As noted in the MHBG Performance Indicator, a total of 3939 individuals with SMI received RRP services and a total of 4093 adults had claims submitted for RRP services. MHA continues to encourage the expansion of the supported living model through which individuals with psychiatric disabilities may access an array of flexible service delivery programs, including PRPs, case management and other supports to enable them to live in housing of their choice. In this model, consumer housing is not dependent on the receipt of services. Persons with SMI also access housing through licensed assisted living providers located throughout the state.

Vocational and Educational Opportunities

MHA has prioritized increasing employment opportunities for individuals with psychiatric disabilities as an important role of the PMHS. MHA and the Division of Rehabilitation Services (DORS) have a Memorandum of Understanding between the state agencies to promote employment for individuals with mental illnesses through training and increased collaboration. MHA staff meets regularly with DORS staff to promote collaborative relationships at both the system level and the individual level toward the evolution of a more cohesive, integrated, and seamless system of services for individuals with SMI who desire successful employment experiences. Budgetary shortfalls had led to an extensive waiting period for DORS-funded vocational services and its temporary closure in FY 2008. However, efforts of mental health advocacy groups, the Maryland Advisory Council on Mental Hygiene/ Planning Council, and other stakeholders resulted in a legislative approval of an increase in DORS budget that led to a reopened and period reduction of the waiting list. Supplemental federal funding through the American Recovery and Reinvestment Act of 2009 has assisted DORS in eliminating the need for the placement of eligible individuals with the most significant disabilities on the waiting list for services.

MHA, in collaboration with the DORS, launched its Evidence-Based Practice (EBP) in Supported Employment Initiative in 2002. Throughout the Initiative, Maryland has consistently ranked first or second, among states participating in the National EBP Project, in the rate of competitive employment achieved across existing EBP sites MHA and DORS received the Crystal Award from the Johnson & Johnson Foundation for the production and filming of an employer-focused job development video in Maryland, sponsored and underwritten by the New Hampshire-Dartmouth Psychiatric Research Center and the Johnson & Johnson Foundation. MHA was also awarded the Science to Service Implementation Award for the dissemination and implementation of Evidence-Based Practice in Supported Employment (SE) in Maryland. [NFC 5]

MHA has worked with the EBPC and other national researchers on dissemination materials and implementation protocols for EBP in SE. As noted in the Adult- Goals Targets and Action Plans section for the Indicator: Evidenced Based Practices, Supported Employment is provided through 52 programs statewide and 2,448 adult consumers received services in FY 2009. Twenty-nine of these programs are participating in the evidence-based practice project in supported employment with 17 achieving fidelity in FY 2010. It is anticipated that additional programs will achieve fidelity in FY 2011. The EBP Initiative is also developing supported employment outcome measures and data collection methods for implementation across all sites.

This year, MHA has used three distinct training modalities: one with the existing Consultant and Trainer at the University of Maryland Evidence-Based Practice Center (EBPC), one through identified Training Resource Programs (TRPs); and one through a Collaborative Learning Implementation Process (CLIP) approach. TRPs are established SE programs which have already been effectively trained in the EBP service approach and which have consistently met all of the requirements to be a model supported

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employment program (SEP). In the second approach, the TRPs have provided a mechanism for the ongoing training and technical assistance in the EBP in Supported Employment (SE) service approach to newly selected SEPs. Access to model TRPs provide collegial support, resource and information sharing, job shadowing, and expert consultation from experienced staff who have been involved in all phases and at all levels of EBP in SE implementation. The third approach is a condensed three-month learning collaborative that incorporates effective features of the two earlier training modalities and is designed to build a community of practice. It is MHA's expectation that this latter training approach will impact greater numbers of programs and their staff.

Under the PMHS, SEPs are reimbursed for providing authorized services during each phase of the individual's course in the program. MHA reimburses for: 1) pre-placement services, including vocational assessment, referral to DORS, service planning, education regarding entitlements and work incentives, and job placement; 2) intensive job coaching, if not otherwise reimbursed; and 3) extended support, at a monthly rate. A new unified supported employment referral, application, authorization, and eligibility determination protocol has been implemented to create a more seamless transition to DORS services upon entry to supported employment within the PMHS. With this protocol, individuals who are eligible for PMHS services, and meet eligibility criteria for supported employment, will be automatically presumed eligible for DORS services and prioritized for DORS funding. Vocational rehabilitation plan development, job development and placement follow immediately, thereby expediting supported employment service provision across the two systems, streamlining and eliminating duplicative administrative processes, and reducing the paperwork burden for DORS counselors and providers. Additionally, supported employment services are available for older adolescents. MHA and DORS work collaboratively to foster an understanding of the needs of youth with psychiatric disorders.

In FY 2007, MHA developed incentives within its rate structure to promote the use of the evidence-based practice (EBP) model of SE. This is continuing into FY 2011 and currently the EBP programs are implemented at 39 sites, which have been trained through one of the various training options. The program sites have achieved adherence to the practice, as evidenced by meeting or exceeding certain MHA defined criteria on a SE fidelity assessment, and are paid a higher rate for these enhanced services than those programs who have not met such criteria. This includes reimbursement for clinical coordination to integrate supported employment efforts with mental health treatment.

The federal Ticket to Work and Self-Sufficiency Program was authorized by the 1999 Ticket to Work and Work Incentives Improvement Act. The program has been phased in across the states and the program is now fully available in Maryland. In July 2010, the ASO, ValueOptions® Maryland will provide access to this service through their website. Under the auspices of this Act, Social Security beneficiaries are eligible to receive a ticket to purchase vocational services from an identified Employment Network (EN). An EN is any qualified entity which has entered into an agreement with the Social Security Administration (SSA) to provide coordination and delivery of employment, vocational rehabilitation, and other support services to eligible beneficiaries in a

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designated service area. Services may be provided directly to the beneficiary or by entering into agreements with other organizations. MHA plans to implement a demonstration project, under the auspices of the new Ticket To Work regulations which connects selected core service agencies (CSAs) in the following jurisdictions: Baltimore City and Baltimore, Carroll, Harford, Howard, and Montgomery counties, and the respective supported employment programs within those jurisdictions, into a single EN consortium. The Ticket program complements the focus on integrated, competitive employment and encourages long-term career development by requiring that SEPs assist individuals to achieve significant levels of earnings. The Ticket Program is an opportunity to reward SEPs for the successful outcomes that they are already achieving and to create incentives to strengthen their ability to support more individuals in competitive employment and at higher levels of wages and hours worked.

A committee formed by DHMH, in collaboration with the Coalition for Work Incentives Improvement and other stakeholders, has continued implementation of a Medicaid Infrastructure Grant. The goal of the grant is to develop the needed infrastructure and operational capacity to permit employed individuals with disabilities to attain and preserve access to Medical Assistance (MA) upon employment. The committee continues to meet monthly with MA's Office of Planning and Finance to coordinate activities to expand and promote a Medicaid Buy-in option for other Medicaid beneficiaries who choose to return to gainful employment. This program, the Employed Individuals with Disabilities (EID) Program began in FY 2007. In FY 2009, the Maryland Department of Disabilities (MDOD) assumed operation of EID.. EID enables consumers to return to work and continue to qualify for Medicaid by paying monthly premiums ranging from \$0 to \$55, depending on the level of countable income. MHA works with On Our Own of Maryland to implement provider-specific and consumer-focused workshops on the EID program. This program is offered to all supported employment sites, psychiatric rehabilitation programs, NAMI affiliates, and On Our Own affiliates. [NFC 2]

During the 2010 fiscal year, OOOMD's certified community work incentives coordinator (CWIC) will provide individualized, one-on-one benefits counseling to consumers utilizing their Social Security Ticket at the Ticket to Work sites that are part of the Maryland Mental Health Employment Network. This pilot benefits counseling is part of a larger statewide initiative within MHA and DORS to build the technical capacity of Evidence-Based Practice (EBP) supported employment providers statewide to facilitate employment-centered benefits counseling and advisement services which encourage individuals with psychiatric disabilities to return to work and to maximize their employment potential by maintaining needed benefits and access to health insurance. On the basis of converging empirical evidence from multiple experimental studies, benefits counseling has been added as the seventh core EBP principle for the effective implementation of EBP SE. Studies indicate that consumers who receive SE and specialized benefits counseling achieve significantly greater earnings from employment than those who receive SE alone.

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In particular, this initiative is designed to assist consumers to: recognize that competitive employment is a viable possibility by explaining to consumers in one-on-one sessions with a certified benefits counselor precisely how employment will affect their benefits; and provide hands-on assistance in accessing available work incentives, as needed. A Benefits Counselor will be in residence at each site for a pre-determined number of hours or days per month, depending on the needs of the agency. In addition to benefits counseling, OOOMD will implement a 90-120 minute workshop about SSI, SSDI, and work incentives for both staff and consumers at the Ticket to Work sites in Maryland.

Access and linkage to educational services are primarily managed through Psychiatric Rehabilitation Programs (PRPs). The rehabilitation assessment includes review of the individual's strengths, skills, and needs for education and vocational training. Based upon the assessment, the individual rehabilitation plan includes a description of needed and desired program services and interventions and, when appropriate, identification of, recommendations for, and collaboration with other services to support the individual's rehabilitation. Some PRPs offer GED programs within their own service continuum, while those who do not have developed the necessary linkages to refer consumers to classes offered elsewhere. Community colleges and local universities in many counties are sites for higher education and a spectrum of low cost/subsidized programs (both federal and state subsidies) are available to individuals with disabilities. Many PRPs utilize a "supported education" model, supporting the consumer in his/her choice and pursuit of education in the community at large. [NFC 2]

Consumer and Family Involvement

Maryland has a rich tradition of an ongoing commitment to consumer and family involvement in planning, policy and program development, and evaluation. MHA has encouraged the input of advocates on all levels. As previously discussed in Section II, Maryland is proud of its commitment to system transformation and maintains a focus on consumer and family involvement to assure that services are continuously examined and redesigned to best support recovery and resiliency. MHA, in collaboration with the Maryland Mental Health Transformation Office (MHTO), has made a number of significant investments in promoting consumer-driven care through several specific programs/initiatives.

The MHA Office of Consumer Affairs (OCA) participates in systems level activities at all pertinent MHA meetings. MHA, in collaboration with the CSAs has supported On Our Own of Maryland's (OOOMD) initiative to transform its consumer network toward a wellness and recovery-oriented system, including enhanced peer support activities and the use of best practices within the community. Maryland has a reputation as a leader in the implementation of Wellness and Recovery Action Plans (WRAP). In FY 2010, an annual Wellness and Recovery Conference was held with over 120 in attendance, mainly focused for providers. The conference generated tremendous interest about WRAP in the provider community. In response to the interest, two three-day WRAP trainings for providers were held. A total of 52 providers and consumers

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participated in the trainings. The trainings were for educational/orientation purposes as well as an opportunity to recruit new facilitators. Three follow-up trainings for existing WRAP facilitators were held this year. The training was successful in engaging consumers and assisting providers in planning for mental health recovery. Maryland now has a total of 90 WRAP facilitators trained in a two year period. WRAP is transformational in that it supports consumer – driven care.

OOOMD, in collaboration with MHA, continues to conduct workshops and trainings through their Recovery Training Project (formerly the Advocacy Training Project). An emphasis on Recovery is a crucial element of a consumer-driven mental health system, capitalizing on consumers' individual strengths and communicating a message of hope. MHTO contracted with OOOMD, to provide training to adult psychiatric rehabilitation programs (PRPs), outpatient mental health clinics (OMHCs), and consumer groups as a step in a longer term effort to assist Maryland's Public Mental Health System (PMHS) to begin or continue to incorporate practices based on recovery into their agencies. Three Workshops have been developed within this project to include "Motivational Vitamins", a workshop that provides information on workforce issues and provides information to help participants to work through common hesitations about entering or re-entering the workforce. "Discovering your Recovery Muse", which approaches recovery from a non-traditional angle introduces participants to better health through various creative processes such as art, dance, music, and writing; which they can use to enhance their recovery. This workshop in FY 2010 reached 202 participants. A third workshop entitled, "Steps to a Healthier You", is designed to motivate and inspire participants to make smarter choices about nutrition, increase physical activity, and develop helpful habits. In FY 2010, this workshop reached 274 participants

The Consumer Affairs Liaison within the Office is involved in coordinating and implementing the Leadership Empowerment Advocacy Project (LEAP). This project has been funded by the MHA since 1990. A major goal of LEAP is to expand the number of consumers playing a prominent role within state and local policy-making bodies. Through participation in LEAP, consumers acquire the necessary skills to become leaders and advocates within the PMHS. LEAP also teaches skills that enhance the participants' ability to direct peer support groups and to hold other consumer-related positions within the state. In FY 2010, the Office of Consumer Affairs offered LEAP to 13 graduates with training on both the state level as well as the federal level allowing them to receive hands on experience within MHA and legislative advocacy as a continuation of their training. LEAP graduates continue to be in high demand for advisory boards, employment and other leadership roles throughout the state. The future goals of the LEAP internship program will be expanded to include placements at state and federal agencies.

The Maryland Consumer Leadership Coalition (MCLC) was created by MHA's Office of Consumer Affairs (OCA) in FY 2008. The MCLC is comprised of leaders in the consumer movement from diverse cultural and organizational backgrounds who work as mental health advocates at the state and national level. Its long-term goals include facilitating leadership and involvement of consumers in their mental health treatment in

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every jurisdiction, and preparing them for the responsibility of partnering with mental health professionals and administrators in shaping the mental health system in Maryland.

The work of MCLC continues to enhance workforce development through the incorporation of peers into the workforce through the involvement of the following: Peer Employment Resource Specialist Training (PERS), Maryland Association of Peer Support Specialists (MAPSS) (501 c 3 organization FY 2009), and the Maryland Consumer Volunteer Network (MCVN). The development and implementation of a curriculum for the Maryland Association of Peer Support Specialists' training manual has been completed with a pilot program to start on the Eastern Shore the Summer of FY 2011. Development and support of a toolkit for (PERS) training to support increased employment of peers in the workforce was developed by the Sar Levitan Center at Johns Hopkins University, MHTO and a team of consumer advocates from MCLC. This initiative was developed for consumers of mental health services who are full or part time staffs of organizations that work with consumers and wish to assist the consumers they serve to enter or reenter the workforce. To date there have been 51 PERS consumer graduates throughout the state. In the summer of FY 2011 PERS training will be held in Western Maryland for consumers.

MHA, in partnership with OOOMD, developed a project under the federal Olmstead Planning Grant titled the Olmstead Peer Support Program. Three Peer Support Specialists (PSS), who are also, WRAP facilitators, worked part-time with patients in three state facilities: Springfield Hospital Center, Eastern Shore Hospital Center, and Finan Hospital Center. In FY 2010 a total of 106 consumers in state hospitals were seen by the PSS staff. The PSS staff facilitates consumer discharges and provides ongoing support during the consumers' transition into the community. PSS staff also provided help and referrals to Wellness & Recovery centers, CSAs, and other organizations that work to enhance recovery. MHA and OOOMD are working with state hospitals to continue to develop procedures to ensure the continued success of the program.

The MHA Office of Consumer Affairs developed and created the Maryland Consumer Volunteer Network (MCVN) as a means of establishing continuity of wellness and recovery concepts to embrace volunteers in the Wellness & Recovery Centers' and board members by hosting a training (MHTO funded part of this initiative) on volunteer concepts to enhance Maryland's commitment to recovery. Over 60 volunteers were in attendance and all received self-help recovery volunteer workbooks to assist them in their volunteer role. Two Webinars' are planned for FY 2011 to move forward with this endeavor.

MHA and its local CSAs have been instrumental in encouraging the development of local advocacy organizations throughout Maryland. In FY 2010, an annual meeting of the CSA directors and the directors of Wellness & Recovery centers was held to re-establish effective communication and continue to develop cohesive strategies to enhance the recovery process through collaborative leadership training. There are 25 Wellness and Recovery centers (formerly known as drop-in centers) in Maryland. Twenty-two of those centers are affiliates of OOOMD. Many of these centers address co-occurring

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disorders of mental illness and substance abuse within their programming. Many other consumer-run support groups are held in the centers on a regular basis. There will be an increased focus on the involvement of the Wellness and Recovery centers in surrounding community organizations and activities to allow the centers and their members to become active members of the greater community.

OOOMD and MHA continue to collaborate to fight stigma within the mental health system through the Anti-Stigma Project (ASP). The ASP uses workshops to help participants identify stigmatizing behaviors and attitudes as well as possible solutions, communication techniques, and actions as vehicles for change. Workshops may be designed and tailored to address specific populations and situations such as issues related to cultural competency, housing, co-occurring disorders, and the reduction/elimination of seclusion and restraint. Workshops are presented in many educational settings, as well as several local Wellness & Recovery centers. OOOMD continues to receive requests for the teaching videotape, "Stigma...In Our Work, In Our Lives", which is now being used in more than 39 states and four other countries. In FY 2010, the ASP presented 51 workshops throughout the state in a wide spectrum of venues, such as housing authorities, homeless shelters, and statewide conferences and universities. Eight hundred and eighty-two people were trained in the full program and reached at least 1,330 more participated on various levels. A new workshop has been added on internalized stigma, "An Inside Look at Stigma," as well as a workshop on creating non-stigmatizing environments.

Work is continuing with international researcher Dr. Patrick Corrigan to establish quantitative measures that will augment the voluminous amount of anecdotes showing the effectiveness of the workshops. This is the first opportunity to scientifically evaluate the program's effectiveness in changing people's beliefs about mental illness and recovery. Results from the evaluation will allow OOOMD to enhance this dynamic program and continue training across the country. Lastly, the creation of a Development Director position at OOOMD will provide consumer organizations with the ability to raise revenue outside of traditional funding sources, thereby expanding its funding base [NFC 1]

MHA and the Mental Health Transformation Office (MHTO) implemented a consumer self-directed care pilot program in Washington County managed through the local Office of Consumer Advocates. The Self-Directed Care program currently has 50 Self-directed care plans developed and approved with 2 full-time and 2 part-time peer Advocates assisting consumers with the process. WRAP training will continue of Peer Advocates and consumer participants with an emphasis on stress reduction and wellness. Peer Advocates help consumers develop and implement their own "recovery plans", which include "directing" the use of their benefits to access both public mental health services and non-traditional support services. The current program now serves consumers in the evenings, on weekends and in the home to meet the need for them to keep timely appointments. There is also a male advocate to address the unique needs of the men in the program.

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Proposal for new MHTO grant submitted to the Substance Abuse and Mental Health Services Administration (SAMHSA); if funded, increased opportunities for career development and wellness and recovery for adults with serious mental illness (SMI) through the integration of: Evidence-Based Practice Supported Employment (EBP-SE) with On-site Benefits Counseling, Self Directed Care, and WRAP

Maryland is very proud of its ongoing Consumer Quality Team (CQT) initiative, now entering its third year, which assures consumer input into quality assurance in the PMHS. To date, the CQT has held confidential, qualitative interviews with more than 1000 consumers. Supported with federal block grant funding, the CQT is transformative as it is the one of the first projects with an emphasis on meaningful involvement of consumers and families in evaluation activities. This is also the first project where the evaluation is consumer-operated. The project also protects and enhances rights by obtaining first hand information from consumers about their experiences in programs and takes an active role in resolving issues right at the program level and, as needed, at other system levels. CQT also conducts monthly feedback meetings with MHA staff, CSAs and providers. Both consumers and program staff have reported significant program changes made as a result of the reports. [NFC 2]

Finally, Maryland provides support to the statewide National Alliance on Mental Illness of Maryland (NAMI MD) organization and its local affiliates. MHA worked successfully with NAMI MD in promoting the NAMIWALKS, a successful kick-off event for promoting *MAY MENTAL HEALTH MONTH*. In 2010, the annual NAMIWALKS that takes place on the first Sunday each May, was expanded to include two major walks one in College Park and one in Baltimore. NAMI MD has developed a strong Family-to-Family Education presence in the state. The “In Our Own Voice” program is an informational outreach program on recovery. Peer-to-Peer is a unique, experiential learning program for people with serious mental illness who are interested in establishing and maintaining their wellness and recovery. With support from MHTO, NAMI MD has begun two initiatives to support the integration of physical and mental health – NAMI MD’s Healthy Hearts and Minds education program and an information dissemination project. Additionally, NAMI MD presents an annual education conference for families, consumers, and providers. In FY 2010 MHA will continue to support NAMI MD’s public education and training efforts. Maryland’s strong, well-developed network of consumer, family, advocacy, and provider participation continues to play an essential role in the ongoing success of the PMHS. [NFC 2]

Case Management

MHA has emphasized implementing the strengths model of case management, which recognizes the individual’s assets and promotes access to services that optimize the individual’s quality of life. Providers have indicated that they utilize various formats in delivering case management. For autonomous case management programs, the broker model, case management services which coordinate and link consumers to community resources, is prescribed by MHA policy.

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Under the PMHS, the ASO collects and reports on data regarding utilization and costs of mental health services. CSAs can review this information and determine whether those individuals with high volume and costly service utilization are receiving appropriate services or whether another strategy, including use of case management, will be helpful in bringing about utilization of the most effective constellation of services.

Case Management Delivery

Over the past several years, the MHA has increased both the availability and comprehensiveness of case management services and had created a mechanism for funding case management activities through CSA contracts. In FY 2010, MHA worked with Medicaid to amend the Medicaid State Plan and regulations for case management. On September 1, 2009, MHA in collaboration with the CSAs and the ASO implemented and monitored the transition from contracted case management services to the fee-for-service system (FFS) for Medicaid recipients and uninsured individuals. Each CSA monitor services and will renew contracts every five years. Information for authorizations are reported to the ASO and payment is based on the level of care that the individual needs in the community. General level allows for less intensive services with a maximum of two face-to-face visits per month while intensive level services allows for five face-to-face visits per month. Reviews for uninsured individuals are monitored by the ASO and CSA. Several counties have also provided case management through the PATH program, Shelter Plus Care community outreach programs, or special jail-based programs. Access to FFS case management for uninsured individuals remains a challenge.

Mobile Treatment /Assertive Community Treatment Delivery

Mobile treatment is Maryland's model which approximates assertive community treatment (ACT). Mobile treatment programs are conceptually defined as combined clinical and case management treatment programs for a specific subset of the MHA priority population, i.e., those individuals who have not engaged in traditional treatment and rehabilitation activities. As of July 1, 2009 twenty-four (25) mobile treatment programs were operating throughout the state, with ten (10) now meeting fidelity to the evidence-based practice model of assertive community treatment (ACT). Regulations require the delivery of clinical and case management services and the availability of multidisciplinary staff, preferably in a team approach.

In FY 2004, MHA was awarded a SAMHSA/Center for Mental Health Services (CMHS) grant for State Training and Evaluation of Evidence-Based Practices. Maryland's application focused on ACT. MHA contracted with the University of Maryland Evidence-Based Practice Center and Systems Evaluation Center to carry out activities under this grant. This grant ended in FY 2009 and trained four existing mobile treatment programs and helped to develop two new ACT teams. The University of Maryland continues to provide training and consultation in the development of ACT teams. Each ACT team has an annual MHA monitoring visit to determine if the program continues to meet fidelity.

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The closure of Crownsville Hospital and reallocation of funds for community-based services afforded the state the opportunity to establish two ACT teams. These teams adhere to the evidence-based practice model and are evaluated according to the Dartmouth Assertive Community Treatment Scale (DACTS) fidelity scales. A wireless system allows for real-time communication and data entry for staff, increasing efficiency and accountability. This project also includes rural areas and an adaptation of the ACT model has been implemented in those areas for both adults and children/adolescents. The adapted in-home intervention teams have a greater rehabilitation focus (rather than clinical treatment) and include implementation of the Illness Management and Recovery evidence-based practice. A modified DACTS fidelity scale measures adherence to the adapted model. In Baltimore City, a Forensic Assertive Community Treatment Team (FACTT), that currently meets fidelity criteria, was established. This team serves up to 100 forensic clients. Individuals with a legal status of Not Criminally Responsible who have lengths of stay of six months or more in state psychiatric facilities are included in the population served by the team.

Other Supports

Medicaid is the joint federal and state program that provides health and long-term care coverage to low-income individuals. The main low-income populations covered under Medicaid include children and their parents, pregnant women, older adults, and individuals with disabilities. Medicaid also covers Medicare cost-sharing for certain low-income Medicare enrollees.

Federal Medicaid requires coverage of the following services: inpatient and outpatient hospital; physician, nurse midwife and certified nurse practitioner; laboratory and x-ray; nursing home and home health care; rural health and federally qualified health centers; and early and periodic screening, diagnosis, and treatment (EPSDT) for children under age 21. EPSDT requires coverage of all medically necessary services, including dental services, for children under age 21. Maryland's Medicaid also covers "optional" services such as medicines, therapies, medical day care, and personal care. A new Medicaid initiative, Medicaid for Families, which began July 1, 2008, provides comprehensive health care coverage to parents and other family members caring for children. Eligibility depends on family size and income. Additionally, funding was increased for Medicaid dental services over the next three years. The state has also set aside additional funds in a grant program for Maryland's 24 jurisdictions to help local governments and non-profits to create new or expanded sources of dental care services that will increase the number of Maryland residents with access to a comprehensive and continual source of dental care. [NFC 4]

In Maryland, about 80% of Medicaid beneficiaries are in HealthChoice, Maryland Medicaid's mandatory managed care program. Individuals choose a primary care provider (PCP) and enroll in one of seven HealthChoice managed care organizations (MCOs). MCOs provide almost all Medicaid benefits, except for certain "carved-out" services that are provided on a fee-for-service basis. Specialty mental health is a key carve-out service. MCOs also provide additional services. For example, Maryland Medicaid does not cover dental services for adults, but all seven MCOs have opted to

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offer a dental benefit to their adult enrollees. The state requires MCOs to cover dental services for children and pregnant women.

Certain individuals are not in an MCO and receive their services on a fee-for-service basis. These populations include individuals who are eligible for Medicare, age 65 or over, eligible for Medicaid under a “spend down” category, continuously enrolled over 30 days in a long-term care facility, or qualify for and opt to be in the Rare and Expensive Case Management (REM) program.

DHMH promotes coordination of MCO and fee-for-service specialty mental health services. Enrollees can self-refer to the Specialty Mental Health System, and Medicaid regulations state that an MCO or an MCO primary care provider (PCP) shall refer an enrollee to the Specialty Mental Health System when the MCO PCP cannot meet the enrollee’s needs. The regulations also state that an MCO shall cooperate with the Specialty Mental Health System in developing referral procedures and protocols.

Meetings among Medicaid and MHA staff, MCO medical directors, and the administrative services organization’s (ASO) medical directors promote coordination. Special needs coordinators at the MCOs currently have access to identified care managers at the ASO, who are specifically commissioned to fulfill this coordinating function. In addition, information on pharmacy utilization is shared across systems. Medicaid receives real-time information on MCO and fee-for-service pharmacy claims in order to prevent drug contraindications at the point-of-sale. On a monthly basis, Medicaid sends reports to each MCO of their enrollees’ fee-for-service mental health drug use, so MCOs and PCPs have information on the mental health drugs their enrollees are taking. [NFC 6]

The Primary Adult Care (PAC) program provides a limited benefit package of primary care, pharmacy, and outpatient mental health services to low-income adults who are not eligible for Medicaid or Medicare. Similar to HealthChoice, individuals in PAC select a PCP and enroll in one of three participating MCOs. Two MCOs have opted to offer a dental benefit as an added PAC service. Individuals in PAC receive their mental health services through the PMHS. Eligibility for PAC is the same as for the previous Maryland Pharmacy Assistance Program (MPAP). Any Maryland resident age 19 and over, who is not on Medicaid or Medicare, and whose income is no more than 116% of the Federal Poverty Level (FPL) and whose assets are no more than \$4,000 may be eligible. For couples/households of two, the income limit is 100% FPL with assets less than \$6,000. All individuals previously enrolled in MPAP moved either to Medicare Part D to receive their pharmacy benefit (if they were Medicare-eligible) or to PAC if they were not Medicare-eligible. The Maryland Pharmacy Discount Program which previously served Medicare recipients was also discontinued with the advent of Medicare Part D drug coverage.

Some individuals who receive services through the PMHS are not Medicaid or waiver-eligible and not enrolled in MCOs, and some of these individuals do not have a regular PCP. CSAs have found innovative ways to promote somatic and dental care for

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uninsured adults in their jurisdictions, e.g., through pro bono initiatives, medical and dental school clinics, or pharmaceutical companies. Additionally, CSAs have been provided with some funds to purchase needed medical/pharmacy/laboratory services for uninsured individuals who cannot afford their costs and for whom no other source of funds or access to the service/drugs are available. These funds are frequently used to prevent the need for more intensive levels of service or reduce the risk of hospitalization. Another resource is the Maryland Medbank Program, which assists low-income, uninsured persons in gaining access to free medicines available through pharmaceutical manufacturers' patient assistance programs. Individuals are referred by their physicians and must meet income and other eligibility criteria set by the supplying drug companies. Only brand name drugs are available and are subject to supply. **[NFC 1]**

The implementation of the federal Health Care Reform, Patient Protection and Affordable Care Act (PPACA) will offer opportunities to strengthen the health care delivery and further expand Medicaid. In Maryland, Governor O'Malley created the Maryland Health Care Reform Coordinating Council through an Executive Order to advise the administration on policies and procedures to implement the recent and future federal health reform as efficiently and effectively as possible. The Council will make policy recommendations and offer implementation strategies to keep Maryland among the leading states in expanding quality, affordable health care while reducing waste and controlling costs.

Hospitalization under the Public Mental Health System

Hospital Utilization. The MHA has promoted the development of community-based services and the concurrent reduction of State psychiatric hospital census for over 25 years. Community expansion initiatives, census reduction initiatives, capitation projects, and demonstration financing projects have been used to affect these reductions in census and increases in community-based services. Over the past twenty plus years, MHA has reduced the operating beds of State-operated psychiatric hospitals from over 2,500 to 1,168 in FY 2010.

In FY 2010, as a result budget reductions and cost containment actions, several changes to the facilities occurred. One change that occurred was the operating bed capacity at the two Regional Institutes for Children and Adolescents. Capacity decreased by forty-six beds. Community residential programs continue to carry some vacancies which enabled the bed shift without hampering services for our at-need youth. Two of our facilities permanently closed. In October 2009, MHA closed Walter P. Carter Center, an acute care State facility in Baltimore City. The functions for the inpatient services moved to Spring Grove Hospital Center. In February 2010, Upper Shore Community Mental Health Center was closed. Services shifted to the community with an infusion of money allowing the Eastern Shore community providers to develop and/or enhance the types of services required and to expand options beyond traditional hospitalization. Residential rehabilitation program (RRP) beds, which are generally utilized when long stay individuals are discharged from the hospital, were earmarked for this population. The Eastern Shore counties developed a variety of services including: assertive community treatment teams; mobile crisis teams; urgent care clinics; in-home

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intervention programs; 24 hour call centers; crisis beds and expansion of the Whitsitt Center. Whitsitt is a residential program designed for the substance abuse population. As a result of the closure of USCMHC, Whitsitt also expanded their mission to include service to the co occurring population: substance abuse and mentally ill.

The Potomac Center hired and trained staff for this specific population. At this time, fifty one individuals have been discharged to the community and an additional eleven have been relocated to the co-occurring (mental illness and developmental disabilities) unit at Potomac Center in Hagerstown. The hospitals are continuing to work with the Potomac Center to prepare for the transfer of the remaining dually diagnosed patients. The patients have been able to participate in DDA programs in the community and are making linkages to supported employment opportunities.

The State continues to face budget challenges. Within MHA, strategic decisions continue to be evaluated to assess the most effective and efficient methods to competently run the mental health system and balance the budget. Community-based services will be further challenged to meet the needs in the community and reduce hospital utilization. MHA, in collaboration with CSAs, will work to strengthen and support community-based services including diversion initiatives.

High occupancy rates, pressure for admissions, and long waits in emergency departments have characterized the total inpatient psychiatric care system, not only the State hospital system. Although total admissions to State psychiatric hospitals have decreased over the years, the type of patient has become more complex. Patients are admitted from the courts and/or have significant histories of court involvement. Consumers involved in the criminal justice system often need court resolution of legal status before they can be discharged from a hospital setting. As the length of stay increases, the total number of people who can be served in a state hospital must decrease, since beds become available less frequently.

The implementation of the hospital diversion initiatives and the increase in purchase of care (POC) beds has contributed to decreased civil admissions to state facilities. POC beds have expanded access to community-based inpatient services. Acute admissions with MA and private insurance are directed to the private or general hospital sectors. State hospital beds currently are used for uninsured individuals (when no general hospital psychiatric bed is available-Maryland's all payor system covers costs of uncompensated care for general hospitals), court-ordered individuals, individuals who have exhausted their private insurance or have already stayed 30 days in the private/general bed and continue to require hospital level care, and for those who require a longer stay in hospital level care. Emergency department visits in general are increasing and while the percentage of visits for mental health reasons remains at its historical level of 4.3%, the overall increase in visits creates a greater number of people seeking mental health dispositions. This past year CMS clarified the Emergency Medical Treatment and Labor Act (EMTALA) policy for receiving hospitals. They cannot turn down an admission because of the individual being uninsured. This should help the ED's move people through quicker.

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In collaboration with CSAs, MHA promotes the use of alternative services to hospital levels of care and facilitates the discharge of long-stay state hospital patients. The PMHS offers several services that can prevent an inpatient psychiatric admission or provide an alternative to psychiatric inpatient admissions. These services include Mobile Treatment Services (MTS) and Assertive Community Treatment (ACT).

In order to better coordinate the efforts of the hospital diversion efforts, MHA convenes a monthly meeting of representatives from the CSAs and state hospitals. This is resulting in more comprehensive systems of care and better clinical outcomes for these individuals.

Olmstead Related Activities. The Maryland Department of Disabilities develops a cross-disability plan that addresses housing, employment, transportation and consumer rights. The 2009 Plan continues to provide direction for Olmstead – related activities for the State and calls upon units of State government to cooperatively engage in a variety of activities to promote consumer self-direction and consumer-centered services. The Maryland Department of Disabilities has become increasingly involved in the housing issues for persons of all disabilities, in order to streamline cross-disability efforts and maximize State and federal resources.

Additionally, MHA expanded residential services in Washington County to serve individuals currently hospitalized in the Finan Center. MHA continues to work with Frederick County to monitor the program assisting transition age youth with mental illness and developmental disabilities, who are aging out of residential treatment centers, in State hospitals, or returning from out-of-state placements. This project is being implemented in partnership with the Developmental Disabilities Administration.

MHA continues to fund and partner with Montgomery County CSA regarding an independent living project using ten Moderately Priced Dwelling Units (MDPUs) for ten individuals from state hospitals. Finally, MHA will continue utilizing the federal Olmstead planning grant to contract with On Our Own of Maryland for peer support counselors in State hospitals who work with consumers, supporting their transition to the community. As noted earlier, a total of 106 consumers in state facilities were seen by Peer Support Specialists (PSS). PSS staff also provided assistance to Wellness and Recovery Centers and to the CSAs.

Traumatic Brain Injury

MHA, which is the lead agency for Traumatic Brain Injury (TBI) in Maryland, is responsible for guiding the State's plans and initiatives for this population. MHA's current TBI initiatives include a Home and Community-Based Waiver for individuals with TBI, which was initially approved by the Centers for Medicare and Medicaid Services in FY 2003 and then renewed for an additional five years in 2006. The waiver was expanded in October 2008 when Maryland changed the definition of institution that is used in the State's Money Follows the Individual Policy to include chronic hospitals. Due to this change, there is currently no cap on the number of TBI waiver slots available to individuals coming out of this setting via the Money Follows the Individual Policy.

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Forty-six individuals were served through this program in FY10. MHA has enrolled two new providers in FY10 to meet the increasing demand for this program and continues to recruit additional providers, especially in the Western part of the state where resources are scarce.. [NFC 2]

Additionally, the Brain Injury Resource Coordination program, which was initially developed with federal grant funding to link individuals with TBI with the community services and supports that they need, was modified in FY10 to support the expansion of the TBI waiver program. Resource Coordinators continue to assist individuals living in the community who are at risk of institutionalization and will begin assisting individuals in chronic hospitals and state-owned and operated nursing facilities who are interested in applying for the TBI waiver program. The TBI project staff also provide education and consultation to local mental health providers and other human service agencies on recognizing the signs of TBI, and strategies for affectively serving and supporting those individuals in the least restrictive setting.

MHA also provides staff support to Maryland's TBI Advisory Board, which is legislatively mandated to report annually to the Governor and the General Assembly on the needs of individuals with TBI, including identified gaps in services and recommendations for needed services and for use of state and federal funds.

Finally, the Baltimore Capitation Project, operational since 1995, continues to prioritize transitioning clients from state hospital facilities to the community. The Capitation Project, created with the philosophy of services for life, has been operating at full capacity for the last several years. Fifty percent (50%) of individuals served through this project are individuals who had hospitalized for longer than six months (often for much longer) and who had not been discharged to the community because their treatment needs, for both somatic and mental health care, were complex. The other 50% are individuals in the community who have frequently been admitted to psychiatric hospitals or have frequently been seen in hospital emergency rooms. In an attempt to open up more slots, BMHS is working with the providers to assist clients in graduating from the program by implementing a recovery approach to services. Borrowing from the evidence-based practice of Illness Management and Recovery (IMR) and Mary Ellen Copeland's Wellness Recovery Action Plan (WRAP) model, the Project is emphasizing effective coping, recovery and the development of a concept of self beyond that of one's illness. Consumers are taught how to minimize the impact of their symptoms through active collaboration with service providers and the use of WRAP plans. Project providers have added community integration specialists to the treatment teams to assist consumers with developing additional roles in the community other than psychiatric client. In addition the project is reevaluating its performance outcomes to better reinforce a recovery approach to services. [NFC 1]

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SFY 2011 OBJECTIVES FOR CRITERION 1:

SERVICES FOR ADULTS

- MHA, in collaboration with the Department of Health and Mental Hygiene (DHMH), the Mental Health Transformation Office (MHTO), the Missouri Office of Transformation, and the National Council for Community Behavioral Health, will continue implementation of the Mental Health First Aid-USA (MHFA USA) initiative for adults and youth in Maryland.

MHA Monitor: Brian Hepburn, MHA Office of the Executive Director, Daryl Plevy, MHTO

- MHA, in collaboration with the Core Service Agencies (CSAs), will continue to provide support, funding, and ongoing consultation to Maryland's mental health advocacy groups to promote and implement a series of public education and training activities to increase awareness of mental illness; mental health issues; and recovery and resiliency among children, youth, and adults.

MHA Monitor: John Hammond, MHA Office of Public Relations; Al Zachik, MHA Office of Child and Adolescent Services; and Cynthia Petion, MHA Office of Planning, Evaluation, and Training

- Provide staff support for the Child, Family, and Special Populations Subcommittee of the Veterans Behavioral Health Advisory Board and technical assistance in identifying licensed behavioral health clinicians experienced in working with and providing services for veterans.

MHA Monitor: Marian Bland, MHA Office of Special Needs Populations

- Convene at least two educational seminars on work incentives to assist consumers with mental illnesses to return to work and retain access to needed benefits and health insurance.

MHA Monitor: Steve Reeder, MHA Office of Adult Services

- Continue to implement the Maryland Mental Health Employment Network (MHEN), a consortium of Maryland mental health supported employment providers and CSAs, to increase and enhance the array of choices of supported employment services available by utilizing Social Security Administration incentives such as Ticket-to-Work.

MHA Monitor: Steve Reeder, MHA Office of Adult Services

- Continue to provide training, technical assistance, and consultation to promote Dual Diagnosis Capability (DDC) in mental health treatment.

MHA Monitor: Carole Frank, MHA Office of Planning, Evaluation, and Training

- Collaborate with the MDQuit Center of the University of Maryland – Baltimore County (UMBC), consumers, providers, and other mental health stakeholders to

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promote and implement the smoking cessation initiatives at all levels in the Public Mental Health System to reduce mortality rates.

MHA Monitor: Brian Hepburn, MHA Office of the Executive Director and Gayle Jordan – Randolph, MHA Office of the Clinical Director

- Continue to facilitate coordination of care activities throughout the Public Mental Health System (PMHS) and study data to determine impact of wellness activities and coordination of care in the provision of community mental health services.
MHA Monitor: Gayle Jordan-Randolph, MHA Office of the Clinical Director
- MHA, in collaboration with CSAs and other stakeholders, will continue efforts to address and implement suicide prevention activities for youth, adults, and older adults.
MHA Monitor: Henry Westray, MHA Office of Child and Adolescent Services
- MHA, in collaboration with On Our Own of Maryland (OOOMD), will support statewide activities promoting the continuance of Wellness and Recovery Action Plan (WRAP) training as part of ongoing efforts to increase the wellness and recovery orientation, enhance peer support activities, and utilize best practices within the consumer movement.
MHA Monitor: Clarissa Netter, MHA Office of Consumer Affairs
- Continue to implement, evaluate, and refine the Self-Directed Care project in Washington County and throughout the state.
MHA Monitor: Clarissa Netter, MHA Office of Consumer Affairs
- Participate in oversight of the Consumer Quality Team (CQT) project and plan for statewide expansion.
MHA Monitor: Clarissa Netter, MHA Office of Consumer Affairs
- Provide resources to continue to implement leadership activities and trainings through the Maryland Coalition of Families for Children’s Mental Health Leadership Institute for parents of children with emotional disorders; the Youth MOVE (Motivating Others through Voices of Experience) peer leadership program; and the Leadership Empowerment and Advocacy Project (LEAP) for adult consumers.
MHA Monitor: Al Zachik, MHA Office of Child and Adolescent Services and Clarissa Netter, MHA Office of Consumer Affairs
- MHA, in collaboration with Maryland Department of Disabilities (MDOD), Department of Human Resources (DHR), Maryland State Department of Education (MSDE), and other stakeholders, will develop integrated home and community-based services and supports for youth and young adults in transition through the Healthy Transitions Initiative demonstration project in Washington and Frederick Counties.

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MHA Monitor: Tom Merrick, MHA Office of Child and Adolescent Services and Steve Reeder, MHA Office of Adult Services

- Continue to work with other state and local funding resources to promote and leverage DHMH's Administration-Sponsored Capital Program grant (Community Bond) funds to support an array of affordable and integrated housing choices for individuals with serious mental illness (SMI).

MHA Monitor: Penny Scrivens, MHA Office of Adult Services

- MHA, in collaboration with CSAs, federal Department of Housing and Urban Development (HUD), local public housing authorities (PHAs), and other federal, state, and local entities, will work with housing infrastructures to improve and increase the number of housing options and funding opportunities for rental assistance for individuals with mental illnesses.

MHA Monitor: Penny Scrivens, MHA Office of Adult Services

- Review, revise and amend Maryland's Medicaid State Plan for community mental health services.

MHA Monitor: Lissa Abrams, MHA Office of the Deputy Director for Community Programs and Managed Care

- Participate in oversight of the Consumer Quality Team (CQT) project and plan for statewide expansion.

MHA Monitor: Clarissa Netter, MHA Office of Consumer Affairs

- MHA's Office of Forensic Services, in collaboration with the Mental Health & Criminal Justice Partnership (MHCJP) and the Interagency Forensic Services Committee (IFSC) – Maryland Advisory Council on Mental Hygiene/P.L. 102-321 Planning Council, will continue to promote the development of services including early intervention, diversion, and re-entry for individuals with mental illnesses who encounter the criminal justice system.

MHA Monitor: Larry Fitch, MHA Office of Forensic Services

- Facilitate community placements, ensure access to somatic and mental health services, and monitor plans of care for consumers with traumatic brain injury (TBI) through the TBI waiver.

MHA Monitor: Stefani O'Dea, MHA Office of Adult Services

- Continue to monitor crisis response systems, hospital diversion activities, and community aftercare services to increase the diversion of inpatient and detention center utilization by individuals with mental illnesses.

MHA Monitor: Lissa Abrams, MHA Office of the Deputy Director for Community Programs and Managed Care

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- MHA, in collaboration with the Developmental Disabilities Administration (DDA), will provide access to and train appropriate MHA and DDA staff in the use of the hospital management information system (HMIS) and the Provider Consumer Information System 2 (PCIS2) data systems to better serve individuals with co-occurring diagnoses in MHA facilities and in the community.
MHA Monitor: Arlene Stephenson, MHA Office of the Deputy Director for Facilities Management and Administrative Operations and Lissa Abrams, MHA Office of the Deputy Director for Community Programs and Managed Care
- Based on a 1987 Lisa L. Program class action lawsuit (which requires timely discharge from hospitals to appropriate placements), track and monitor children and youth in state custody in designated psychiatric hospitals as identified under Code of Maryland law (COMAR) 14.31.03.
MHA Monitor: Marcia Andersen and Musu Fofana, MHA Office of Child and Adolescent Services
- MHA's Office of Special Needs Populations, in collaboration with the Core Service Agencies, and selected local providers (local detention centers, hospitals and mental health clinicians) will partner with National Association of State Mental Program Directors (NASMHPD) and others to provide training and disseminate information regarding trauma-informed systems of care.
MHA Monitor: Marian Bland and Darren McGregor, MHA Office of Special Needs Populations

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- Continue to interface and maintain liaison efforts with other agencies and administrations to support a comprehensive system of behavioral and somatic health and other services and community supports.

Maryland State Government

MHA Monitor

Maryland Department of
Disabilities (MDOD)

Brian Hepburn
MHA Office of the Executive
Director

Governor's Office for
Children (GOC)

Al Zachik, Tom Merrick and
Marcia Andersen
MHA Office of Child and
Adolescent Services

Governor's Office of the
Deaf and Hard of Hearing
(ODHH)

Marian Bland
MHA Office of Special Needs
Populations

Maryland State Department
of Education (MSDE)

Al Zachik, Cyntrice Bellamy, and
Joyce Pollard
MHA Office of Child and
Adolescent Services

Division of Rehabilitation
Services (DORS)

James Chambers and
Steve Reeder
MHA Office of Adult Services

Department of Human
Resources (DHR)

Lissa Abrams
MHA Office of the Deputy
Director for Community
Programs and Managed Care
Al Zachik
MHA Office of Child and
Adolescent Services
Marian Bland
MHA Office of Special Needs
Populations

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Department of Housing and
Community Development
(DHCD)

Penny Scrivens
MHA Office of Adult Services
Marian Bland
MHA Office of Special Needs
Populations

Maryland Department of
Aging (MDoA)

James Chambers and
Marge Mulcare
MHA Office of Adult Services

Department of Public Safety
and Correctional Services
(DPSCS)

Larry Fitch
MHA Office of Forensic Services
Marian Bland
MHA Office of Special Needs
Populations

Department of Juvenile
Services (DJS)

Al Zachik and
Cyntrice Bellamy
MHA Office of Child and
Adolescent Services
Larry Fitch
MHA Office of Forensic Services

Department of Veterans
Affairs

Marian Bland, Office of Special
Needs Populations

Judiciary of Maryland

Larry Fitch
MHA Office of Forensic
Services

DHMH Alcohol and Drug
Abuse
Administration (ADAA)

Pat Miedusiewski
DHMH

DHMH Family Health
Administration
(FHA)

Al Zachik and Joyce Pollard
MHA Office of Child and
Adolescent Services

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DHMH Developmental
Disabilities Administration
(DDA)

Stefani O'Dea
MHA Office of Adult Services
Lisa Hovermale
MHA Office of the Executive
Director
Debra Hammen
MHA Office of Forensic
Services

Maryland Health Care
Commission (MHCC)

Brian Hepburn, MHA
Office of the Executive Director

Health Services Cost
Review Commission
(HSCRC)

Brian Hepburn
MHA Office of the Executive
Director

The Children's Cabinet

Al Zachik
MHA Office of Child and
Adolescent Services

DHMH Office of Health
Services (Medical
Assistance)

Brian Hepburn, MHA Office of
the Executive Director
Lissa Abrams, MHA Office of
the Deputy Director for
Community Programs and
Managed Care
Gayle Jordan-Randolph
MHA Office of the Clinical
Director

DHMH Office of
Operations and Eligibility
(Medical Assistance)

Brian Hepburn
MHA Office of the Executive
Director
Lissa Abrams,
MHA Office of the Deputy
Director for Community
Programs and Managed Care

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DHMH Office of Health
Care Quality (OHCQ)

Sharon Ohlhaber
MHA Office of Quality
Management and Community
Programs

DHMH Office of Capital
Planning, Budgeting, and
Engineering Services

Cynthia Petion
MHA Office of Planning,
Evaluation, and Training

DHMH AIDS
Administration

Marian Bland
MHA Office of Special Needs
Populations

Maryland Emergency
Management
Administration (MEMA)

Arlene Stephenson
MHA Office of the Deputy
Director for Facilities
Management and
Administrative Operations

ADULT PLAN

CRITERION #2: Adult Mental Health System Data Epidemiology

Mental health transformation efforts and activities in the state are described within the narrative for each criterion and then referenced to the specific goal(s) in the New Freedom Commission (NFC) Reports.

PMHS DATA SYSTEM

The primary PMHS data system is currently managed by an Administrative Services Organization (ASO). On September 1, 2009, a new vendor, ValueOptions Inc. was selected to contract as the new ASO for the Public Mental Health System (PMHS). Historical data from the previous vendor was transferred to ValueOptions. Historical data have also been placed at the University of Maryland Systems Evaluation Center (SEC). The SEC provides enhanced capacity for analysis of the data, particularly in relation to evaluation and outcome efforts.

The data system collects information on those who receive services in the fee-for-service system. The system is driven by a combination of authorizations and claims for mental health services. Inherent in the implementation of the PMHS is a series of extremely comprehensive data sets. Data sets on client's service authorization and events and the provider community are available. Client information is accumulated through either the Medical Assistance (MA) eligibility file or the subsidized client data forms. Unduplicated counts are calculated by using MA numbers, Social Security numbers, and/or unique identifiers. Authorizations are made on-line and added to available data. Provider data come from provider enrollment files, which are used both for referral and for payment of claims. Finally, event and cost data are derived from claims files.
[NFC 5]

The ASO is contracted to support mental health services access, utilization review, and care coordination tasks. The PMHS data are collected and displayed by demographic, clinical service, provider and outcome information relative to an episode of care, and also link multiple consumer records into useful "episodes of care." The PMHS data system through a series of interrelated databases and software routines can report over 200 elements for both inpatient and outpatient care. Also included among the numerous data fields, care management elements, and outcome indicators are:

- service authorizations and referrals
- services utilized by level of care and service
- treatment service lengths and number of units provided
- site visits, including record reviews and second opinion (peer) reviews of authorization

All stored data can be retrieved and reported either in standard form, using an automated reporting system or by way of custom programming or ad hoc reports. The data may be formatted to produce monthly, quarterly, or fiscal reports. Maryland operates on July-June fiscal year. Over 50 standard reports are generated to assist in

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general planning, policy, and decision making. The data may also be accessed to produce an unlimited range of reports via ad hoc requests. Data, when available is shared with the Maryland Advisory Council on Mental Hygiene/PL 102-321 Planning Council.

Implemented in July 2007, information on Medicaid drug prescriptions filled by consumers in the PMHS are available through the ASO. These prescriptions are for all medications other than HIV medications, regardless of prescriber. This information is accessible to providers of mental health services. It is available to those providers with existing open authorizations to treat the consumer. The pharmacy is refreshed monthly and includes prescriptions filled during the 12 months prior to the refresh date. Information is now made available to Managed Care Organizations (MCOs), who can then communicate it to their primary care physicians. The availability of this new module has enhanced service quality and provided a rich resource to enhance data analysis efforts. **[NFC 6]**

An unanticipated problem resulting from PMHS implementation contributes to an undercount of persons with mental illness. The ASO Management Information System (MIS) does not capture data for individuals who receive no services reimbursed by MA and have Medicare as their only payer source. These Medicare reimbursed services cannot be subject to authorization and claims are not paid by the ASO, the two mechanisms for capturing data. Additionally, beginning July 1, 2003, claims for individuals who are qualified for federally matched MA and have Medicare, began to be processed by Medical Assistance and the data on their utilization of Medicare reimbursed services is no longer in the ASO data system. Therefore, the data on those served in the PMHS represents an undercount.

Tables on the following pages provide data on consumers served by age group in FY 2009 and 2010. FY 2010 data shows that thus far 117,498 individuals had claims submitted for mental health services through the fee-for-service system. Of the total 70,517 are adults, and 46,981 are children.

Access to services is critical for any mental health system. In recent years and as an ongoing strategy in the FY 2011 State Plan, MHA will “continue to monitor the system for growth, maintaining an appropriate level of care for at least the same number of individuals in the populations who have historically utilized the PMHS”. Data relevant to this national indicator on access to services continue to support the achievement of this target.

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The ASO MIS was utilized to produce most of the data included as performance indicators in this application. Data for FY 2009 are based on claims paid through August 31, 2010, FY 2010 data is projected based on claims paid through June 30, 2010 and historical SMI utilization. Since claims can be submitted up to twelve months following the date of service, the data for FY 2010 is still incomplete. Full year projections were not made for FY 2010. Specific diagnoses were used to define SMI. An individual was categorized as SMI if, at any time during the fiscal year, a diagnosis in the specific categories was submitted on a claim. Due to the transition of the ASO, the PMHS data is currently being processed for validation. Once data is approved for release, information will be updated and adjusted as appropriate performance indicators may change.

The MHA submitted its application to SAMHSA/CMHS for a third round of Data Infrastructure Grant in June 2009. The required Basic and Developmental Tables were submitted in December 2009. All tables will be submitted this year, including developmental tables based on new consumer survey items. Data for these come from three sources. Community data are obtained from data that results from claims, authorizations, and the Outcomes Measurement System (OMS) which are within the ASO system. Some data, such as employment status and residential status along with detailed racial and ethnicity data, are not available from either standard claims or MA eligibility data sets. Efforts are made to obtain this information in the ASO system through requirements for registration and authorization by providers for services. The ASO information is supplemented by an annual Consumer Satisfaction and Outcomes Survey for many National Outcome Measures (NOMs), though the newly implemented OMS may allow MHA to move to client level reporting for some of these measures. Data from state operated inpatient facilities are obtained from a Hospital Management Information System (HMIS). Currently, information is abstracted from the HMIS and integrated into data from the community system to complete all required Uniform Reporting System (URS) and NOMs reporting. While this system does not use the same consumer identifiers at the ASO data system, there are elements common to both which MHA has used to establish a nearly unique identifier based on demographic variables. This identifier has been used to link data from the two systems. This system, which has been in place since 1986, is scheduled for replacement. Data for those tables reporting on individuals served and services provided are collected and reported at the person level. **[NFC 5]**

In addition to the ASO, MHA contracts with the Systems Evaluation Center (SEC), a component of the Mental Health Services Improvement Collaborative of the University of Maryland School of Medicine, Department of Psychiatry, Division of Services Research to assist with evaluation and data infrastructure activities. As MHA's strategic partner, SEC maintains a copy of the community services' data repository which extends back to 1999. The SEC has accepted responsibility for the oversight of the effort to collect the data necessary to complete the URS tables required to be included with Maryland's Mental Health Block Grant application. The SEC, ASO, and MHA are working jointly to further develop the OMS, described more fully in Criterion 5. In this coming year, the SEC will continue to collaborate with MHA and key stakeholders to identify areas of interest related to the PMHS that could be analyzed using multiple

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databases. These databases include claims, authorization, the consumer satisfaction and outcomes survey, the OMS, the HMIS, Medicaid, and other state databases, as available.

Additionally, through Maryland's StateStat, MHA is also responsible for providing information on agency performance and priority initiatives. StateStat is a performance measurement and management tool implemented by the Governor to make our state government more accountable and more efficient.

INCIDENCE AND PREVALENCE FOR ADULTS

Maryland has revised its methodology for the calculation of prevalence according to the federal regulations. For adults, the current estimate of population aged 18 and over for each county was multiplied by the rate cited in the federal definitions (5.4%).

Estimates of treated prevalence however; were of necessity based upon a somewhat stricter definition of SMI. Specific Axis I and II diagnostic codes were selected to identify the SMI treated in the system. Very slight modifications were made within the diagnostic categories this year. All data have been updated to reflect these changes. A mechanism to define levels of functioning through the data system is not available, hence the reliance on diagnoses. As Maryland has implemented the PMHS, careful consideration has been given to maintaining services to the previously defined priority populations in both the fee-for-service and contract-based systems.

Family and other surrogate caregivers should also be prioritized for services as research has shown that these persons are at high risk for the development of their own mental illnesses, particularly depression, as a result of their caring for a person with psychiatric disabilities. Maryland's priority population remains as follows:

"Priority population" means those adults for whom, because of the seriousness of their mental illness, extent of functional disability, and financial need, the Department has declared priority for publicly-funded services.

Priority population includes:

- An adult, aged 18 to 64, with a serious and persistent mental disorder, which is a disorder that is:
 - Diagnosed, according to a current diagnostic and statistical manual of the American Psychiatric Association as:
 - Schizophrenic disorder,
 - Major affective disorder,
 - Other psychotic disorder, or
 - Borderline or schizotypal personality disorders, with the exclusion of an abnormality that is manifested only by repeated criminal or otherwise antisocial conduct; and
- Characterized by impaired role functioning, on a continuing or intermittent basis, for at least two years, including at least three of the following:
 - Inability to maintain independent employment; social behavior that

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- results in intervention by the mental health system,
 - Inability, due to cognitive disorganization, to procure financial assistance to support living in the community,
 - Severe inability to establish or maintain a personal social support system, or
 - Need for assistance with basic living skills.
- An elderly adult, aged 65 or over, who:
 - Is diagnosed, according to a current diagnostic and statistical manual of the American Psychiatric Association as:
 - Schizophrenic disorder,
 - Major affective disorder,
 - Other psychotic disorder, or
 - Borderline or schizotypal personality disorders, with the exclusion of an abnormality that is manifested only by repeated criminal or otherwise antisocial conduct; or
 - Experiences one of the following:
 - Early stages of serious mental illness, with symptoms that have been exacerbated by the onset of age-related changes,
 - Severe functional deficits due to cognitive disorders and/or acute episodes of mental illness, or
 - Psychiatric disability coupled with a secondary diagnosis, such as alcohol or drug abuse, developmental disability, physical disability, or serious medical problem.
- An individual committed as not criminally responsible who is conditionally released from a Mental Hygiene Administration facility, according to the provisions of Health General Article, Title 12, Annotated Code of Maryland.

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**Mental Hygiene Administration
Prevalence Estimates for Serious Mental Illness (SMI) by County
Adult Population**

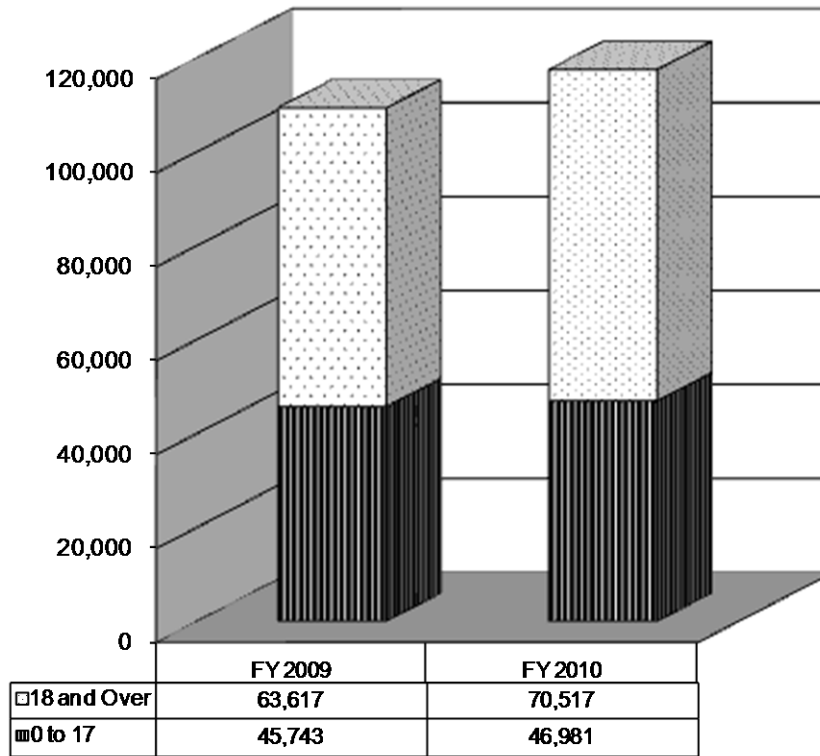
County	Over 18 Population	Prevalence 5.4%
Allegany	58,961	3,184
Anne Arundel	390,296	21,076
Baltimore County	611,294	33,010
Calvert	66,865	3,611
Caroline	25,084	1,355
Carroll	128,736	6,952
Cecil	75,514	4,078
Charles	103,802	5,605
Dorchester	25,234	1,363
Frederick	168,080	9,076
Garrett	23,300	1,258
Harford	181,036	9,776
Howard	206,081	11,128
Kent	16,395	885
Montgomery	722,032	38,990
Prince George's	619,379	33,446
Queen Anne's	36,253	1,958
St. Mary's	75,368	4,070
Somerset	21,469	1,159
Talbot	29,156	1,574
Washington	112,453	6,072
Wicomico	72,355	3,907
Worcester	40,106	2,166
Baltimore City	483,765	26,123
Statewide Total	4,293,014	231,823

Data Source:

July 1, 2008 Estimated Maryland Total Population by Age Group, Region and Political Subdivision

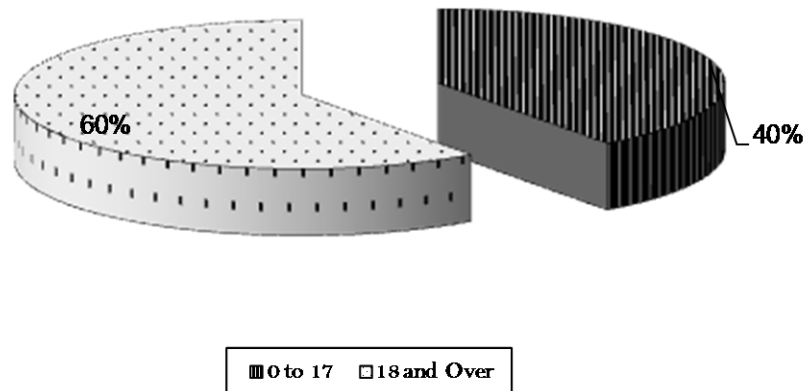
MARYLAND MENTAL HEALTH BLOCK GRANT APPLICATION FY 2011

Total PMHS Consumer Counts for FY 2009-2010 by Age Group



Source: VO-MD Data report MARF0004. Based on Claims Paid through 06/30/2010. FY2010 data is incomplete as claims may be submitted up to nine months from date of service.

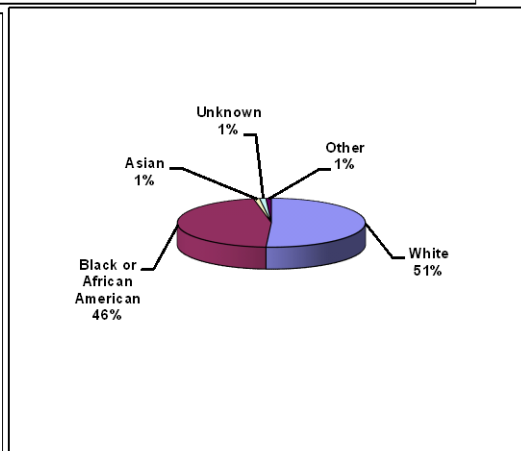
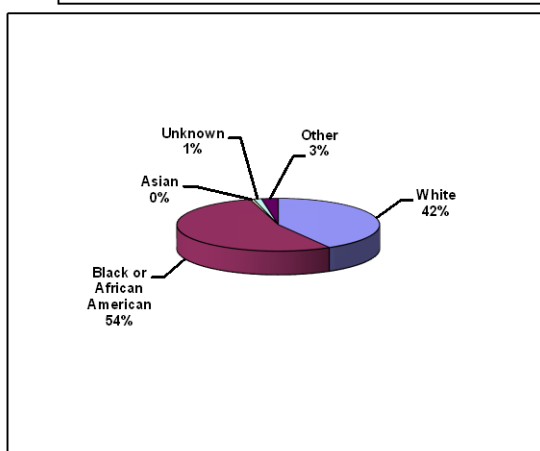
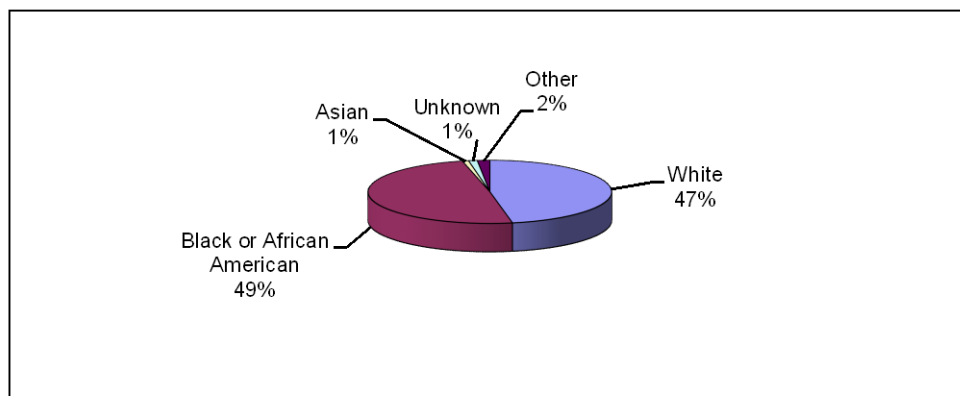
Percentage of PMHS Consumer Counts for FY 2010 by Age Group



Source: VO-MD Data report MARF0004. Based on Claims Paid through 06/30/2010. FY 2010 data is incomplete as claims may be submitted up to nine months from date of service.

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**Total Consumer Served in
in FY 2009 by Race and Age Group**

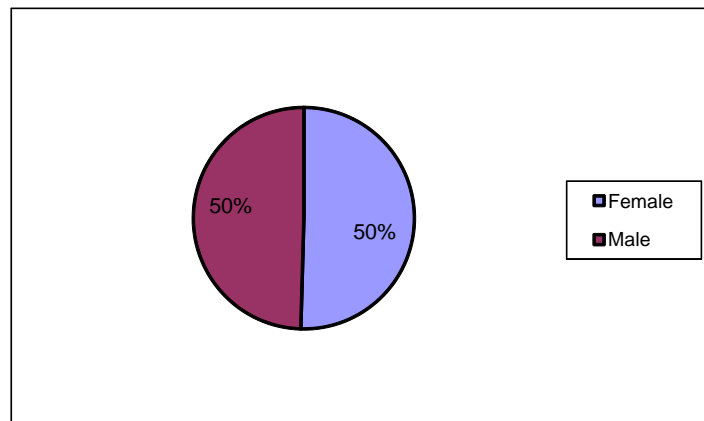


Source: FY 2009 URS Table 2A

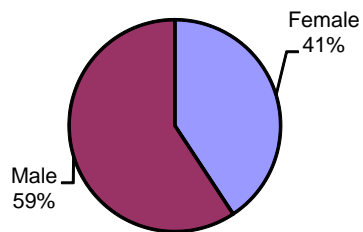
Note: Other includes : American Indian,Native Hawaiian, Pacific Islander and those consumers with more than one race.

MARYLAND MENTAL HEALTH BLOCK GRANT APPLICATION FY 2011

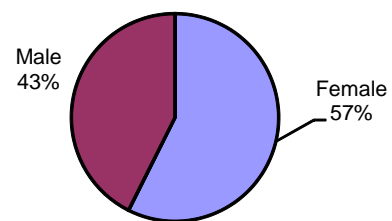
**Total Consumer Served
in FY 2009
by Gender and Age Group**



Age 0 -17



Age 18 and Over



Source :FY 2009 URS Table 2A

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SFY 2011 OBJECTIVES FOR CRITERION 2:

SERVICES FOR ADULTS

- MHA, in collaboration with On Our Own of Maryland (OOOMD), will support statewide activities promoting the continuance of Wellness and Recovery Action Plan (WRAP) training as part of ongoing efforts to increase the wellness and recovery orientation, enhance peer support activities, and utilize best practices within the consumer movement.

MHA Monitor: Clarissa Netter, MHA Office of Consumer Affairs

- In collaboration with CSAs and stakeholders, monitor the ASO contractual obligations and performance, monitor the system's growth and expenditures, identify problems, and, as needed, provide corrective action and maintain an appropriate level of care for at least the same number of individuals.

MHA Monitor: Lissa Abrams, MHA Office Deputy Director for Community Programs and Managed Care

- Enhance capacity for stakeholders to utilize PMHS data to measure service effectiveness and outcomes.

MHA Monitor: Susan Bradley, MHA Office of Management Information Systems and Data Analysis

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ADULT PLAN

CRITERION #3: Not Applicable

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ADULT PLAN

CRITERION #4: Targeted services to rural, homeless, and older adult populations

Mental health transformation efforts and activities in the state are described within the narrative for each criterion and then referenced to the specific goal(s) in the New Freedom Commission (NFC) Reports.

TARGETED SERVICES FOR RURAL POPULATIONS

Definition of Rural Areas

Rural counties have historically been defined in Maryland as those with a population of 35,000 or less. Six counties continue to meet this criterion. Source: U.S. Census Bureau, Estimated Maryland Total Population by Political Subdivision, July 1, 2008 - Maryland Vital Statistics Annual Report 2008.

Maryland's definition was reviewed relative to the more complicated definitions of rural used by the U.S. Census Bureau. For Census 2000, the Census Bureau's classification of "rural" consists of all territory, population, and housing units located outside of urbanized areas (UAs) and urban clusters (UCs). The Census Bureau also looks at the population density with core census blocks of at least 1,000 people per square mile or surrounding census blocks with an overall density of at least 500 people per square mile. Many counties and metropolitan areas are split with UAs and UCs, often mixed with more rural areas. Based on population density alone, several other counties in Maryland, beyond the six, might be considered rural. However, other factors, including growth rate and proximity to major metropolitan areas (emerging bedroom communities), make these counties appear less rural. Based upon these factors, the six counties with populations under 35,000 will remain Maryland's defined rural areas for purposes of this application, while recognizing that pockets of "rural" areas exist in other counties.

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Of the six Maryland counties that qualify under this definition, one rural county—Garrett—is the western-most jurisdiction in the state, and the other five—Caroline, Dorchester, Kent, Somerset, and Talbot Counties—are on the Eastern Shore. In recent years, several Eastern Shore counties have developed past the 35,000 threshold. Typically, as a rural county develops beyond the 35,000 threshold, it experiences growth in housing, commerce, and average household income that makes it more similar to the rest of the State. (** Talbot County, with 36,215 slightly exceeds this threshold. Please see discussion of Talbot County on following page.)

Rural County Population -- March, 2009	
Caroline	33,138
Dorchester	31,998
Kent	20,151
Somerset	26,119
Talbot**	36,215
Garrett	29,698

Source: U.S. Census Bureau, Estimated Maryland Total Population by Political Subdivision as of March, 2009

While the Mental Hygiene Administration will continue to utilize the foregoing definition of rural counties for purposes of this Mental Health Block Grant Application, the Office of Health Policy and Planning of the Maryland Department of Health and Mental Hygiene in June 2007 published *The Maryland Rural Health Plan* which provides a broader discussion of rural health issues in Maryland. The following are excerpts from that plan to assist us in identifying and addressing rural mental health issues in this analysis.

“The challenges to providing quality health care services and delivery to rural Maryland largely result from their geographic isolation and lack of the critical population mass necessary to sustain a variety of primary and specialty services. Efforts to address health care disparities in rural areas are often made difficult by struggling economies and limited financial and human resources.”

“Compared with the state overall, Maryland’s rural communities tend to have fewer health care organizations and professionals, higher rates of chronic disease and mortality, and larger Medicare and Medicaid populations. Evidence indicates that rural populations fare worse in many health and economic indicators, and do not receive the same quality, effective, and equitable care as their suburban counterparts. Rural populations tend to be older and exhibit poorer health behaviors such as higher rates of

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smoking and obesity, relative to the State, although there is variability in health behaviors among rural communities.”

The DHMH Office of Rural Health convened a steering committee to create the Maryland Rural Health Plan. Among the top priority areas for rural health in Maryland identified by the Steering Committee were behavioral health (mental health and substance abuse) and improvement in behaviors leading to a healthier lifestyle.

For purposes of data analysis and comparison, all Maryland jurisdictions where at least two-thirds of the census tracts are classified as rural by the federal Office of Rural Health Policy (ORHP) are included in the “federally designated rural” group. These jurisdictions tend to fare worse in the health and economic status because they are generally more isolated and have smaller and older populations than the other jurisdictions. The ORHP classifies the following three additional counties in addition to the previously identified six jurisdictions as rural: Allegany County (with 72,238 population); St. Mary’s County (with 101,578 population); and Worcester County (with 49,274 population-year round/non summer). It is worthwhile to note that rural issues apply to other areas beyond the six most rural counties discussed in this rural section of Maryland’s mental health block grant analysis.

**Talbot County is an excellent example of a county that is in the process of transforming from a rural to non-rural area. On July 1, 2003 the population was 34,670. On July 1, 2007, the last year in which official age specific population was available, the number increased to 36,215 exceeding Maryland’s self defined “rural” threshold of 35,000 by 1,215 -1,193. Projections indicate that the population of Talbot County continued to increase approximately 0.06% in 2008. For purposes of this year’s block grant application, we will continue to include Talbot County among the six rural counties – (Utilization data from all six counties are used in the block grant performance indicator). Talbot County now has an average per capita personal income of \$56,775, up from \$51,947 in 2006, (Department of Business and Economic Development <http://www.choosemaryland.org/factsandfigures/demographics/incomedata.html>).

The five Eastern Shore rural counties have personal per capita incomes ranging from a low of \$24,053 in Somerset County to the high of \$56,775 in Talbot County, compared to a statewide average per capita personal income of \$48,091. The demographics of Somerset County and most of the Shore counties also reflect issues affecting rural areas. As the second smallest county in the state, Somerset County’s population actually increased slightly by +103 individuals after a decline in a recent previous year according to the July 1, 2008 DHMH Vital Statistics estimates. Somerset County’s 2004 household median income was one of the lowest in the State at \$33,700. Statewide household median income was \$70,545 over the past five years, the number of Medical Assistance Program enrollees has risen (Economic updates from Maryland Manual 2005 estimate printed 6/24/08).

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Garrett County, in western Maryland, provides a useful example of how rural communities differ from jurisdictions in more rapidly developing areas of the State. Garrett County has one of the lowest per capita incomes (\$29,820) of the State's 24 subdivisions. The 2010-2011 Core Service Agency (CSA) Plan notes that Garrett County has 819 families, or 9.8% of the 8,354 families who live in poverty. In 2007, the median household income was \$40,150 (Maryland Department of Business and Economic Development): Garrett County ranks 21st out of 24 counties in the state, for total personal income. Unemployment rates in Garrett County are almost double that of the State of Maryland. According to the July 2007 Maryland Department of Labor statistics, the annual average unemployment rate ranged from 4.5%-4.8% in one year. Current data for April 2009 estimates a 7.3% unemployment rate in Garrett County compared to a 6.6% statewide rate, (Source US Department of Labor). In Garrett County, of the adults in the age group 25 and over, 7% have less than a ninth grade education or no diploma; 79.2% have a high school or higher education. (Statewide Web-based data indicate that in March 2009 a total of 6,345 out of the total county population of 29,627 were Medicaid eligible.) The current plan indicates 18.6% of the county residents, among the highest of Maryland jurisdictions, are enrolled in Medical Assistance.

In its FY 2009 CSA Plan Update, Garrett County is described as a, rural, mountainous county in the northwestern most corner of Maryland. This area of the Appalachian Mountains has high elevations with severe winter conditions. The average yearly snowfall is over seven feet. The majority of roads are winding, the nearest large city with mental health services is Cumberland, Maryland, located in Allegany County. Limitations, typical of rural areas exist in availability of transportation, access to healthcare and health information for a number of socioeconomic, geographic, educational, and cultural reasons. Low education levels create a barrier to seeking and understanding health information. However, in April 2009 access to primary health care services was improved when a new permanent Federally Qualified Health Center (FQHC) opened on property adjacent to the Garrett County Health Department and a major mental health outpatient clinic (OMHC). There was a 5.6% increase for persons served in the OMHC from 2008 to 2009. The plan notes that some of the OMHC increases resulted from more children 6-12 being served. In FY 2011, the CSA will continue to promote a mental health service delivery system which is locally driven and addresses housing, employment, transportation, and community support for consumers and their families.

Use of Technology

The best example of the use of technology in Maryland is the statewide launch of The Network of Care. The Network of Care is an information Website cited as a "best practice" for the use of technology in the President's New Freedom Commission Report on Mental Health. The site contains a listing of services; a library of mental health articles; a list of support and advocacy organizations; legislation; and a personal folder/advance directive/Wellness Recovery Action Plan (WRAP) feature. The goal is to provide simple and fast access to information for persons with mental illnesses, caregivers, and service providers. The Website was first piloted in Worcester and Anne

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Arundel Counties. The official statewide launch was held at the annual summer conference of On Our Own of Maryland, Inc. (OOOMD) in June 2008. Phase II of the Network of Care initiative reached out to consumers in all of Maryland's 24 jurisdictions who now have access to information and resources in their communities. The Maryland Network of Care for Behavioral Health continues to enhance Maryland residents' ability to access consumer driven and recovery oriented information regarding available mental health services. The Maryland Network of Care for Behavioral Health has recorded 294,006 sessions from its May 30, 2008 launch date through August 31, 2009. Since its March launch through August 31, 2009, the site has recorded 9,544 sessions.

The Network of Care site added a comprehensive Veterans' portal to help service men and women returning from Iraq and Afghanistan with behavioral issues obtain access to services. In response to the increasing numbers of returning veterans, Maryland was the first state in the country to launch the Network of Care for Veterans & Service Members. This site, kicked off by Lieutenant Governor Anthony Brown on March 31, 2009, is a one-stop-shop arrangement, bringing together critical information for all components of the veterans' community, including veterans, family members, active-duty personnel, reservists, members of the National Guard, employers, service providers, and the community at large. This public service is an attempt to bring together critical information for all components of the veterans' community, including veterans', family members, active duty personnel, reservists, members of the National Guard, employers, service providers, and the community at large.

In FY 2010, MHA collaboration with Mental Health Transformation Office (MHTO) and CSAs, to improve implementation and provide training on Network of Care improved outcomes will include: Web-based platform purchased and installed throughout Maryland, utilization of site tracked, improved user friendliness, mental health community informed regarding availability of Web system, consumers trained in the utilization of personal health record features, and training in use of individual advance directives.

Since November 2008, the Mental Hygiene Administration and the University of Maryland's Department of Psychiatry has partnered with three Core Service Agencies (CSAs) to provide psychiatric care in seven rural counties in the state. This tele-psychiatry program allows individuals living in rural areas to see a psychiatrist in Baltimore without traveling from their home communities. Clinical services began in December 2008.

In FY 2011 Maryland established Telemedicine for rural areas and underserved groups, such as people who are deaf and hard of hearing. Responsible parties include: University of Maryland - Department of Psychiatry MHA and Mid-Shore CSA. This initiative will enhance the number of sites utilizing telemedicine to increase access to services. Financing strategies include eventual Medicaid reimbursement. Once telemedicine equipment is installed at Springfield Hospital's Deaf unit, services will begin for this site. The TeleMental Health Alliance continues to convene on a quarterly basis.

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Additionally, the Mental Hygiene Administration, the Johns Hopkins University (JHU), and the University of Maryland (UMD) have partnered to develop the Maryland Youth Practice Improvement Committee for Mental Health (MYPIC) to provide video advice to improve mental health care for youth. Video conferencing technology has greatly improved the level of communication among providers. Seven different sites from across the state were able to participate and discuss, in real time, the latest advances regarding medication and treatment. The sites included the Johns Hopkins University, the University of Maryland, Spring Grove Hospital Center, Finan Hospital Center, and the two Regional Institutes for Children and Adolescents. Teleconferences began and continue to be held monthly, facilitated by the Directors of the UMD and the JHU Divisions of Child and Adolescent Psychiatry. **[NFC 3, 6]**

Sheppard Pratt Hospital Systems was awarded a grant from the U.S. Department of Agriculture (USDA) several years ago to install and furnish telemedicine equipment at several public and private mental health facilities in the State to improve access to care, using IP lines to provide real-time interactions between psychiatrists and patients. Three units were set up in Worcester County in conjunction with the grant. Worcester County Health Department Core Service Agency, with funding from the Mental Hygiene Administration, contracted with Sheppard Pratt to provide telepsychiatry services to clients who were homeless with mental illnesses and substance abuse problems. The Worcester County Health Department Core Service Agency has since expanded on these services by funding mental health treatment to children and adolescents. Sheppard Pratt was also awarded a grant by the Health Resources Services Administration (HRSA) to purchase equipment, train providers, and establish a telepsychiatry disaster network at several general hospitals and community mental health clinics in Maryland.

Sheppard Pratt has completed a telepsychiatry inpatient attending physician demonstration project, one of the first in the country, with a general hospital on the Eastern Shore. The general hospital was in need of psychiatric coverage during a time of staff turnover, a common problem for rural general hospitals in Maryland; as well as most other states. The hospital funded the professional fees portion of the pilot project as a demonstration of inpatient telepsychiatry utilization. Finally, a twice-monthly mental health grand rounds professional education program is provided via interactive video-conferencing to a number of hospitals and mental health clinics in Maryland. Additionally, in FY 2010, Sheppard Pratt began providing telemedicine services to children and adolescents at the Behavioral Health Clinic, an outpatient facility in Wicomico County.

Correctional Mental Health Services began utilizing telepsychiatry in 2004 at the St. Mary's' County Detention Center as part of a comprehensive program to provide mental health services to incarcerated individuals. This program currently provides telepsychiatry services at the St. Mary's, Charles, and Wicomico County Detention Centers. Through this program, both live and telepsychiatry services are provided to all sites which utilize telepsychiatry.

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MHA, in collaboration with CSAs, is now working to develop parameters for telemedicine, including its use to address access issues for remote locations, specialty services, and special needs groups. The Maryland Association of Core Service Agencies (MACSA) applied for grants, (USDA and HRSA) to obtain funding for the purchase of equipment and has partnered in this grantsmanship effort with the Mental Hygiene Administration and the University of Maryland Department of Psychiatry. In May 2008 HRSA approved the grant for telemental health equipment in rural areas. The grant is for three years with a two-year renewal possibility. The University of Maryland Department of Psychiatry has 90 psychiatrists, many board certified, who will implement the telemental health project with Medical Assistance (MA) patients from these rural areas. MHA is providing funding for the psychiatrists services which will eventually be reimbursed by MA. Telemental health has been piloted in 26 other states. Additionally, in FY 2011, Cecil County CSA will begin implementation of telepsychiatry, supported through block grant funding. [NFC 6]

MHA partnered with the University of Maryland's Department of Psychiatry to submit a grant application on March 6, 2009, for the federal Health Resources and Services Administration (HRSA) funding in order to develop a Center of Excellence on Telemental health for Special Need Populations. The Center of Excellence on Telemental Health will improve access to culturally competent services for the deaf and hard of hearing population. In rural communities, MHA's Office of Special Needs Populations in collaboration with Mid-Shore Mental Health Systems and Gallaudet University, has promoted a series of trainings, as well as explored the use of the Web to increase cultural awareness and sensitivity to the needs of individuals who are deaf or hard of hearing. This includes application of new communication and technology, i.e. video phone, telepsychiatry, and Web-based training.

Available Services

At present, the range of mental health and support services in rural counties is similar to those that are available in urban and suburban jurisdictions. Some services in contiguous counties are provided by programs that provide services at multiple sites throughout the area served. Mental health providers in rural areas have a history of cooperation and coordination as well as a history of sharing resources, with each other and with other service related agencies, to address the service needs of specific populations. Through this cooperation, providers have developed innovative services that are tailored to the unique needs of their areas. [NFC 3]

The maintenance of effective core service agencies (CSAs) is a key statewide strategy to meet rural needs. The Mid-Shore Mental Health Systems, Inc. (MSMHS) is the CSA responsible for public mental health services in Caroline, Dorchester, Kent, Queen Anne's, and Talbot counties, located on Maryland's Eastern Shore. MSMHS is currently the only regional CSA in Maryland. Of these five MSMHS counties, Queen Anne's County with a population of 47,091 was added to the Baltimore-Washington metropolitan region after the 2000 Census and is no longer considered a rural county.

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In its Community Mental Health Fiscal Year 2010 Plan Update and the FY 2011 Plan Update, MSMHS discussed the rural nature of counties in the region. Population per square mile ranges from 55.4 persons per square mile in Dorchester County to 130.1 per square mile in Talbot County, with a regional average of 89.9. The Plan emphasizes that in “planning processes to improve the system of care to assure consumer focus and one (system) that is recovery oriented, it is apparent that the unique needs of the rural jurisdictions must be given a priority.” “In the absence of a number of valuable mental health services that are difficult to replicate in rural communities, the CSA uses the spirit of cooperation to break down barriers to access and choice whenever possible”.

The MSMHS reported special initiatives and collaborative efforts targeted towards specific populations which include individuals with mental illnesses who are homeless, dually-diagnosed (mental illness and developmental disabilities), have co-occurring disorders (mental illness and a substance addiction), are deaf or hard of hearing, returning military veterans, transition-age youth and individuals whose mental health needs are coupled with a forensic background.

In FY 2010 and the FY 2011 Plan Update, the MSMHS reported on the following accomplishments:

- MSMHS partner with the consumer council to develop peer-support programming in each county and to promote efforts to become certified in the Copeland WRAP mode. MSMHS worked with a consultant to facilitate the development of a new peer support organization to serve the Mid-Shore region. A contract with Chesapeake Voyagers Wellness and Recovery Center was initiated. In July 2009, the new center opened the doors to the main location in Easton, MD and has built a strong base of membership serving 114 consumers in the first year.
- Forensic Mental Health Coordinator: MSMHS has partnered with the Circuit and District Court judges to create two regional positions that will offer the criminal justice system in each jurisdiction an opportunity to provide consumers with mental illnesses voluntary, community-based assessment and treatment alternatives to traditional methods of criminal behavior punishment through: 1) access to a licensed mental health professional who understands systems management and resources in the region and can recommend and monitor those alternatives which improve outcomes to people historically poorly-served by detention centers, 2) Monitoring of offenders in court ordered evaluation, 3) recommendations regarding community-based treatment, and 4) facilitation of ongoing communication and collaboration where criminal justice, mental health, substance abuse, and related systems intersect. (This new initiative is supported by a reallocation of community mental health block grant resources. Success will be measured by the program’s ability to lead individuals to effective community treatment and break the cycle of recidivism in the courts and detention facilities.)

In July 2009 a new Forensic Case Manager was hired to assist with diversion planning, case management services, and tracking mental health treatment and resources connections. In the first quarter of FY 2010, 36 new referrals were received for services

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and 12 consumers were still being served as carryover from the previous fiscal year. At the close of the 1st quarter, a total of 48 unduplicated consumers had received services. The goal of this program is to reduce the recidivism rate of those defendants, with mental illness, in the court system by providing linkage to mental health treatment and case management.

- MSMHS has taken the role of the lead agency for the HUD Continuum of Care (COC), and was successful in the development of 35 Shelter Plus Care permanent housing units, 17 permanent supportive housing units, and a regional Homeless Management Information System. Increased availability of affordable housing/homeless shelters was one of three prioritized regional needs identified by stakeholders. The COC has engaged three faith-based groups that have volunteered to operate shelters in the region. [NFC 3]
- MSMHS and its providers promote a long-term recovery model for consumers with serious mental illness (SMI) and have developed outcome measures for PMHS community based services. MSMHS collaborated with local providers to develop outcome measures for contractually funded services, as well as for selected services within the fee-for-service system, including adult psychiatric rehabilitation programs, residential rehabilitation programs, and supported employment.
- MSMHS continues to participate on the Governor's Office of Deaf and Hard of Hearing Mental Health sub-committee, supporting the development of a statewide needs assessment and inventory of mental health services available to individuals who are deaf or hard of hearing and will develop a state proposal to include recruitment and training of culturally competent mental health professionals. Many representatives are active on the local and state mental health advisory council. Recruitment of licensed mental health professionals proficient in American Sign Language remains a challenge, and the provision of care for Deaf and Hard of Hearing consumers continues through the use of interpreters. MSMHS contracted for a training series in partnership with MHA and Gallaudet University Department of Social Work entitled "Culturally Competent Practice for Person Who are Deaf and Hard of Hearing." Webcasts from each session in the series are available on the GUDSW website for three years and are fully ADA compliant and accessible with closed captioning.
- The closure of Upper Shore Community Mental Health Center has produced an opportunity for the expansion of the continuum of community-based care across the entire Eastern Shore. Additional resources to be added to the continuum before the end of FY 2010 include an Eastern Shore Operations Center, mobile crisis teams, crisis beds, same day outpatient appointments, mobile treatment teams (To become Assertive Community Treatment Teams), residential rehabilitation program for co-occurring disorders population, and supported-employment – evidence based practice.

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After several years of moderate expansion, Somerset County CSA (SCCSA) has worked to maintain the array and number of services available. As the second smallest county in the state, Somerset County's population actually increased slightly by 242 individuals after a decline in the previous year, according to the July 1, 2007 DHMH Vital Statistics estimates. Somerset County has only seen a 5.6% growth in population in the past 10 years, with little of that growth in recent years, and has one of the lowest median income rates in the state. These factors make it important to avoid duplication of effort and to acknowledge the need for collaboration with both in-county and tri-county (Somerset, Worcester, and Wicomico) stakeholders on planning, service expansion, and coordination of activities and efforts. The Tri-County Provider Forum continues to meet to discuss issues regarding the PMHS and to increase provider knowledge.

The state budget constraints of the past year had a significant impact on the Lower Eastern Shore Core Service Agencies. FY 2010 saw cuts of \$87,011 for Wicomico and Somerset CSA's, on top of the 5% overall reductions that had already been implemented. As a result of these and projected future budget reductions in FY 2011, Somerset CSA was unable to sustain the staffing and services necessary to maintain a freestanding CSA. In October, 2009, the two agencies merged into one operation identified as the Wicomico Somerset Regional Core Service Agency or WSRCSA.

The partnership of Eastern Shore Core Service Agencies has been integral to the success in serving the Wicomico-Somerset region. The newly developed Community Alternatives Framework (CAF) is one such example of the good work that comes from cross jurisdictional efforts. As a result of the closure of the Upper Shore State Hospital Center, WSRCSA worked with Mid-Shore CSA in planning and implementation efforts to ensure consumers and families will have alternative services available to them. The expanded services array will include: 24/7 Eastern Shore Telephone Operations Center, limited mobile crisis response services, a newly expanded urgent psychiatric evaluation service, assertive community treatment team, additional crisis bed service and more.

In the Wicomico Somerset Regional Core Service Agency Annual Plan Update for FY 2010-2011 and the original FY 2010-FY2011 Plan, the Somerset County Core Service Agency reported on the following accomplishments:

- WSRCSA continue to support MHA in identifying new and innovative ways to effectively manage the small pool of state only funds allocated for individuals who are uninsured that need services from the PMHS. Staff work diligently to help uninsured consumers access the various coverage options that they may be eligible for through the State such as the PAC (Primary Ambulatory Care) program, Medical Assistance for Families, and the Employed Individuals with Disability (DID) program.
- Collaborated with Department of Human Resources to implement regional mental health mobile crises and stabilization services to Department of Social Services (DSS) foster care involved youth and families in the three lower counties of Somerset, Wicomico, and Worcester.

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- Partnered with the Family Services Division of the Circuit Court to update and re-distribute the county resource guide;
- Support increased participation in Lower Shore Friends developing plans to implement the Wellness and Recovery Action Plan (WRAP);
- Participated in the statewide effort to launch a mental health and human services Website called Network of Care (NOC) to assist individuals, families, and agencies concerned with behavioral health;
- Continued working in partnership with the other CSAs on the lower shore and received a HUD grant to provide housing in the tri-county region to address permanent housing; and
- Partnered with Seton Center, a local affiliate of Catholic Charities, to provide mental health educational information in the Spanish. **[NFC 3]**

The Fiscal Year 2010-11 Plan and FY 2011 Plan Update for the Garrett County Core Service Agency (GCCSA) included recent accomplishments. Highlights included:

- The Garrett County Core Service Agency is planning to continue operating as a single county CSA during FY 2011 despite budget reductions. In order to maintain its operation, CSA staff have taken reduced time and worked part time with other health department programs.
- Extensive collaboration and partnerships to improve services to children, youth, and adults in areas related to school mental health, peer support, addictions services, trauma and jail services, suicide prevention, and disaster planning.
- A statewide initiative for service coordination for veterans began in FY 2009. Two outpatient mental health programs in Garrett County have participated and the Western Region Resources Coordinator presented information to the community on the program at the Local Mental Health Advisory Committee (LMHAC) meeting.
- Services to Older Adults are important to maintain access to care in aging rural communities. Geriatric Mental Health Workgroup meets on a regular basis, planned depression screening at senior centers and continues with geriatric outreach. The Older Adults Transition Service (OATS) social worker continued to provide outreach, support and training for volunteers. This mental health professional links older adults to community services and provides consultation to nursing home staff, assisted living providers, and adult medical day service providers on mental health issues. **[NFC 4]**
- GCCSA continued the Adventure Sports Institute (ASI) of Garrett College, which operates the Transition-Age Youth (TAY) project. TAY graduates now act as mentors to incoming TAY participants. The Garrett County Commissioners and Garrett College have agreed to provide support for the third year of this successful project.
- Garrett County Sunrise Support Group for Survivors of Suicide will continue to meet with the GCCSA providing assistance and public awareness activities
- The Federally Qualified Health Center (FQHC) provided access to primary health care services on property adjacent to the Garrett County Health Department. There was a 5.6 % increase for persons served in the outpatient mental health

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clinic (OMHC) from 2008 to 2009. The plan notes that part of the OMHC increases resulted from more children 6-12 (one of the identified targeted population) being served.

- Closure of the Garrett County residential crisis services, Safe Harbor, contributed to an increase in inpatient expenditures for individuals utilizing the local emergency room with more complex problems requiring inpatient hospital stays.

The following table provides an overview of the six rural counties and the major programs available. Not included in the table is the broad array of individual providers in these rural communities.

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CONTINUUM OF MENTAL HEALTH SERVICES	Mid-Shore Mental Health Systems	Somerset County CSA	Garrett County CSA
Advocacy- Adult and Child	X	X	X
Community Support Funds(pharmacy, lab, transportation, other needs)	X	X	X
Detention-Based Mental Health Services	X	X	X
Inpatient Services Adult Adolescents Child	X X X	X (youth and family services in Crisfield)	Emergency Room only
Intensive Outpatient Services	X		X
Intensive In-Home Services	X	X	X
Outpatient Mental Health Adult Child and Adolescent	X X	X X	X X
Peer Support Services	X	X	X
Psychiatric Rehabilitation Program Adult Child and Adolescent	X X	X X	X X
Respite Care Adult Child	X X	X X	X
Supported Employment Services	X	X	X
Transition Age Youth Programs	X	Go-Getters provided six residential slots	X
Targeted Case Management Adult Child and Adolescent	X X	X X	X

Service Needs

In order to best assess local service needs and implement services to meet those needs, MHA strongly supported the development of CSAs in rural counties. As noted previously, all rural counties in Maryland are served by CSAs. The rural CSAs are challenged to plan, both independently and collectively, for their residents' needs and the most efficacious use of resources. All CSAs are required to include a description of their needs assessment process and findings, including gaps in services, in their local mental health planning documents. The consistent and recurring service needs identified are: adequate number and mix of providers, need for specialty service providers, transportation, crisis treatment services, and efforts to address the needs of individuals with co-occurring disorders.

One of the major challenges for a rural area is the recruitment, retention, and ongoing training of mental health professionals. The number of qualified professionals in the Mid-Shore area has increased over time and this may be attributed to the growing nature of some of the Mid-Shore counties. Conversely, in its FY 2009 Plan Update, the Garrett County Core Service Agency reports that there is only 1.6 full-time equivalent of psychiatrist time available in the county. The need for psychiatric care for the child and adolescent population is acute. Garrett County and Kent County (as well as a number of very urban census tracts in Baltimore City with special needs related to the homeless population) are designated by the federal Department of Health and Human Services, Bureau of Primary Health Care as mental health professional shortage areas (MHPSA). MHPSA designation may provide needed assistance in the recruitment of physicians.

In FY 2010-11 Plan, the Somerset County Core Service Agency identifies the development of services in rural areas as presenting multiple challenges. Accessing services is difficult, especially with limited transportation services. Available resources are scarce compared to urban areas. There are severe shortages of specialized mental health professionals and providers. Additionally, stigma continues to be an issue.

Like many rural areas, Somerset County providers are having problems attracting and keeping behavioral health professionals, particularly psychiatrists and therapists. Additionally, psychiatrist availability can be limited. One clinic in Somerset County closed new intakes for approximately one year due to having limited psychiatrist time. In the Wicomico Somerset Regional Core Service Agency Annual Plan Update for FY 2010-2011 and the original FY 2010-2011 Plan, the Somerset County Core Service Agency identified the following areas of need to continue to address:

- Maintaining collaborative initiatives locally, regionally and statewide;
- Increasing awareness and public knowledge about mental illness and mental health resources;
- Developing strategies that address ending chronic homelessness among individuals with mental illnesses;
- Addressing the need for integrated services for individuals with mental illnesses, substance abuse, and developmental delays; and

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- Developing and implementing outcomes management objectives for all contractual obligations.

CSAs, in both rural Western Maryland and rural Eastern Shore, have identified the need to travel to adjacent counties for some services as a significant rural issue. Transportation to and from services has been a barrier not only for appointments but for consumers attempting employment and increasing involvement in their local communities. Due to the lower population density and greater distances to all types of services, rural mental health programs have acquired and operate vehicles to link individuals to services, both through mobile services and by transporting consumers to needed services. Local health departments and community action agencies also provide some publicly-supported transportation in rural counties. Additionally, CSAs have some funding in their budgets for transportation services for eligible individuals. Stigma also plays a significant role as a barrier to accessing mental health services, particularly in rural settings. The CSAs on the Eastern Shore and Lower Shore Counties work collaboratively with stakeholders to address stigma through workshops and public awareness activities.

In Mid-Shore Mental Health Systems, Inc.'s (MSMHS's) Community Mental Health Plan for Fiscal Year 2009 and 2010, a good discussion is provided of the local needs assessment process and results. The Plan discusses disproportionate representation of ethnic groups in the lower income range and the impact of the search for affordable housing as suburban counties see rapid increases in housing costs. In a chart designed to show the Mid-Shore region's continuum of care for public mental health, clear gaps in crisis services are shown. (A same day appointment service has been successfully used as a stop-gap measure.) Also the plan identifies another critical gap with regard to jail mental health delivery in the region's detention centers.

MSMHS, in collaboration with other community programs, recognizes the need for mental health services for Hispanic consumers that are uninsured. The Mid-Shore Council on Family Violence has two bilingual client advocates. For All Seasons, an OMHC, applied for a grant to obtain funding for a bilingual interpreter and MSMHS will provide the cost of the therapist, and limited psychiatrist time. **[NFC 3]**

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The Garrett County Core Serve Agency's (GCCSA's) 2010-2011 Mental Health Plan focuses on solidifying and enhancing existing programs. Efforts will focus on:

- Coordination and collaboration with consumers, family members, providers and other county and state stakeholders to assure accessibility to quality mental health services;
- Implementation of Telepsychiatry services at the Garrett County Community Mental Health Center to improve consumer access to skilled mental health professionals. Telepsychiatry continues to be a service well utilized by approximately 25 youth and has helped increase availability of access to child psychiatric service which has long been identified as a need in Garrett County;
- Strengthening the consumer-run center and fostering a more cohesive consumer movement for quality-based mental health services;
- Expansion of geriatric mental health services;
- Development of a continuum of community- based housing services for individuals who have severe mental illness;
- Continuation of suicide prevention activities;
- Ongoing development of services for the co-occurring population;
- Identification of funds and programs which are targeted to increasing evidence-based practices mental health services for children and adolescents and their families;
- More supported employment opportunities/work sites for those individuals who want to work;
- Increased availability of child psychiatry services- the health department hired a part-time psychiatrist leading to a decrease in the wait time for initial medication evaluation appointments for new mental health consumers; and
- Continued availability of outpatient and psychiatric rehabilitation program providers.

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SFY 2011 OBJECTIVES FOR CRITERION 4:

SERVICES FOR ADULTS

TARGETED SERVICES FOR RURAL POPULATIONS

- Explore efforts to enhance communication and education through use of social media tools and networks.
MHA Monitor: Susan Bradley, MHA Office of Management Information Systems and Data Analysis
- Collaborate with the Maryland Advisory Council for the Deaf and Hard of Hearing, the Governor's Office of Deaf and Hard of Hearing (ODHH), CSAs, advocates, and other involved parties to implement standards identified by DHMH to enhance access to services that are culturally competent, clinically appropriate, and recovery-oriented for individuals who are deaf or hard of hearing.
MHA Monitor: Marian Bland, MHA Office of Special Needs Population
- Enhance PMHS data collection and monitoring through continued activities to develop and/or refine management information systems.
MHA Monitor: Susan Bradley, MHA Office of Management Information Systems and Data Analysis

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ADULT PLAN CRITERION #4

TARGETED SERVICES TO THE HOMELESS

The exact number of children and youth in Maryland who are homeless and who have mental health problems is unknown. MHA has been participating in the efforts of the Maryland Department of Human Resources (DHR) and local communities to implement the Homeless Management Information System statewide. All of the Maryland counties have established a system and most of the counties have trained shelters' staff and providers on utilizing the Homeless Management Information System. Some counties are still working to resolve issues regarding providers' resistance to using the Homeless Management Information System due to concerns about client confidentiality. Data are not broken out by age as a part of the survey. Efforts are also underway to develop a statewide data warehouse so that local homeless data may be accessed at the state level. **[NFC 6]**

DHR gathers and reports information only on people who have stayed in emergency shelters, transitional housing programs or who have received emergency motel placements. The data reflects the extent of shelter services provided to people who are homeless as reported by emergency shelter and transitional housing providers on a Homelessness Services Survey form. The data in DHR's report does not include an absolute count of the number of homeless people in Maryland.

According to DHR's FY 2008 Annual Homeless Report, there were 37,955 persons served in Maryland's homeless shelters. This is a 3.5% increase from FY 2007 in which 36,599 persons were in shelters. There were 27,469 people served in emergency shelters, 5,910 served in transitional housing, and 4,576 served through motel placements. Of this amount, it is estimated that there are 9,492 homeless sheltered persons who have a mental illness in Maryland. It is estimated that there were about 3,176 non-sheltered homeless people in Maryland in 2007, using the National Alliance to End Homelessness estimates of the unsheltered homeless.

SSI/SSDI Outreach, Access, and Recovery (SOAR). Individuals who are homeless can benefit from Medicaid enrollment to obtain needed services. The purpose of SOAR is to expedite and increase the number of successful SSI/SSDI applications for all eligible applicants. In FY 2010, MHA re-launched and expanded the pilot initiative in Baltimore City and Prince George's County, and allocated funding for two SOAR Outreach specialist. MHA also funded a part-time Data and Evaluation Consultant position.

During FY 2010, over 50 applications have been submitted within Maryland using the SOAR process. The overall approval rate for Maryland is over 90%. Baltimore City, which has submitted the most applications, has a 100% approval rate for new applications. The initiative has seen significant growth in recent months. The following areas have active working groups: Baltimore City, Anne Arundel, Howard, Montgomery, Prince George's, and the Lower Eastern Shore counties (Somerset,

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Wicomico, and Worcester). Five 2-day trainings were held in FY 2010, training over 150 case managers, mental health professionals, and social workers.

In FY 2011, MHA has obtained additional PATH funding for two more SOAR outreach positions. It is anticipated that the focus in FY 2011 will be on those counties that are currently implementing SOAR, or who have already actively begun the planning process.

Services for Runaway and Homeless Youth. The unmet needs of youth that are homeless are extensive, particularly the needs of the runaway and homeless adolescents with serious emotional disturbance. A special project, for runaway and homeless youth, continues in Ocean City, Maryland, the state's major beach resort area. Located in Worcester County on the Eastern Shore, Ocean City increases from a relatively small community to a population of close to 400,000 in the summer. Many runaway and homeless youth frequent the resort, some experiencing serious psychiatric disorders, almost all involved, in some way, in drug and alcohol abuse. The agencies in the community have formed a successful collaborative consortium to coordinate shelter, primary health, substance abuse, mental health, and other human services for this population. The project serves youth from all areas of the rest of the Maryland and large numbers of youth from other surrounding states in the region. Federal community mental health block grant funds have been allocated for mobile crisis services in Worcester County. This project is intensively staffed. [NFC 5]

Services for Children in Homeless Families. MHA has funded and provided technical assistance to a project for young children who are homeless because their mothers and other family members live in family shelters throughout Baltimore City. The Parents and Children Together (PACT) program provides a therapeutic nursery at the YWCA shelter in Baltimore City, and extensive consultation at The Ark, a day care program that serves many of the children who reside in family shelters across the entire city. This population is reported to experience significant developmental delays, particularly in language acquisition.

Children and adolescents with serious emotional disturbance in families that are homeless can access Maryland's Projects for Assistance in Transition from Homelessness (PATH) and Shelter Plus Care programs for services. PATH funds are used for outreach, engagement, case management, screening and diagnostic services, consultation to shelters, training, housing assistance, supportive services in residential settings, and mental health and substance abuse services. PATH funded case managers are located in shelters, detention centers, and service agencies, facilitating outreach and access to services in a timely manner. PATH provides outreach and access in urban, suburban, and all rural areas in Maryland. These services also link individuals and families to the fee-for-service system. The PATH Program is targeted to homeless consumers who have serious mental illnesses or co-occurring substance use disorders, who are disconnected from the community and lack the necessary supports to obtain permanent housing.

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The PATH program provided services in 23 counties and Baltimore City in FY 2010. In SFY 2009, the funding level was \$1,172,000. Local PATH supported agencies identified 3,632 homeless individuals with mental illnesses. Of these, 1,949 actually enrolled for PATH services. In FY 2010, PATH was increased by \$140,000 which funded SOAR Outreach Specialists in Baltimore City and Prince George's County and a Data and Evaluation Consultant. In FY 2011, PATH was increased by another \$115,000. In FY 2011, PATH will be funded at \$1,287,000, and is projected to enroll an estimated 2,402 individuals and families. The following table presents a summary of the most current PATH program information:

SERVICE AREA OF PROJECT	ADMINISTRATIVE ENTITY	PATH SFY 2011 FUNDING	PROJ. # SERVD. SFY 2011	SERVICES PROVIDED UNDER PATH
Allegany County	Allegany County Mental Health Systems	\$54,955	40	ALLEGANY COUNTY MENTAL HEALTH SYSTEMS - Community outreach, case management, staff training, housing assistance, supportive services, referrals to primary health services, job training, educational and relevant housing.
Anne Arundel	Anne Arundel County Mental Health Agency	\$48,100	80	Anne Arundel County Mental Health Agency –PATH/SOAR assistance with SSI/SSDI, linkage to community mental health resources, case management, outreach to homeless, emergency shelter and transportation arrangements, linkage to intensive outpatient treatment and transitional housing.
Baltimore City	BMHS Baltimore Mental Health Systems, Inc.	\$335,756	355	BALTIMORE MENTAL HEALTH SYSTEMS BMHS to provide technical assistance in locating and developing affordable housing, room and board training, registry of house resources.
				UNIVERSITY OF MARYLAND MEDICAL SYSTEMS- SSI outreach, linkage to services and housing, case management, liaison to homeless outreach teams, outreach assessment.

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SERVICE AREA OF PROJECT	ADMINISTRATIVE ENTITY	PATH SFY 2011 FUNDING	PROJ. # SERVD. SFY 2011	SERVICES PROVIDED UNDER PATH
				HEALTH CARE FOR THE HOMELESS-Street outreach, SSI Presumptive Eligibility Project, mental health and addictions treatment, and case management. SOAR Outreach Specialist to develop and maintain relationships necessary to achieve more rapid SSI/SSDI application approvals, including relationships with SOAR partners, Disability Determination Services, Social Security Administration, Policy Research Associates, Mental Hygiene Administration and others. Provide technical assistance to case managers and other SOAR trained providers with outreach to homeless individuals and completing SSI/SSDI applications for benefits.
				PRISONER'S AID ASSOCIATION- Outreach, case management, linking women who have a history of mental illness and trauma to services and housing
				CHRYSLIS HOUSE HEALTHY START PROGRAM - 16 bed diagnostic and transitional facility for pregnant and post-partum women and their babies. The participants will be women who are incarcerated in local detention centers and have misdemeanor charges. Comprehensive assessment, outreach assessment, housing assistance, case management, access to appropriate treatment resources and services will be provided.
				STATEWIDE TRAINING – 2 day SOAR trainings and 1-day refresher training, workshops on homelessness at Special Populations one-day conference.

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SERVICE AREA OF PROJECT	ADMINISTRATIVE ENTITY	PATH SFY 2011 FUNDING	PROJ. # SERVD. SFY 2011	SERVICES PROVIDED UNDER PATH
Baltimore County	Dept. of Health Bureau of Mental Health CSA	\$96,200	150	PROLOGUE, INC. – Outreach, screening and diagnostic services, training, case management, housing coordination and matching, security deposits, one-time rentals (eviction prevention), support and supervision in residential settings, staff training.
Calvert County	Calvert County CSA	\$30,380	124	CALVERT COUNTY MENTAL HEALTH CLINIC Outreach, screening, case management relevant housing services, referrals for primary health, community mental health services, substance abuse treatment, job training programs, educational services.
Carroll County	Carroll County CSA	\$37,000	50	KEYSTONE SERV.OF MD – Outreach, intensive case management, screening and diagnostic treatment, assistance with linking to housing and services linking to training, support in residential settings.
Cecil County	Cecil Co CSA	\$5,000	8	CECIL COUNTY CORE SERVICE AGENCY -One time only rental assistance, security deposits and training, contract with outreach and case management services.
Charles County	Charles County CSA	\$35,000	75	SOUTHERN MARYLAND DIVISION OF CATHOLIC COMMUNITY SERVICES – Outreach, referral to intensive case management, mental health services, linkage to mental health services, screening and diagnostic treatment, assistance in planning for housing, technical assistance with housing, referrals to alcohol and drug treatment, medical care, pharmacy assistance, job training, educational legal assistance, and assistance with security deposits.

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SERVICE AREA OF PROJECT	ADMINISTRATIVE ENTITY	PATH SFY 2011 FUNDING	PROJ. # SERVD. SFY 2011	SERVICES PROVIDED UNDER PATH
Frederick County	Frederick County CSA	\$77,400	300	FREDERICK COMMUNITY ACTION AGENCY – Outreach, case management, referrals for health care, job training, alcohol and substance abuse treatment, transportation, housing coordination, supportive and supervisory services, and the development of Med bank services to link PATH clients to free prescription medications made available through patient assistance programs.
Garrett County	Garrett County CSA.	\$24,500	29	GARRETT COUNTY CSA. - Screening, housing coordination, security deposits, one - time only rental assistance linkage to permanent housing, and referrals for mental health and other services.
Harford County	Harford Co CSA	\$71,524	95	CORE SERVICE AGENCY IN COLLABORATION WITH ALLIANCE, INC. – Outreach, case management, linkage to housing, assessments, and referrals, substance abuse and assertive treatment services, services to prevent re-incarceration and improve access to services upon release from incarceration.
Howard County	Howard County CSA	\$35,478	25	GRASS ROOTS CRISIS INTERVENTION CENTER – Case management, psychiatric services, referral, housing assistance, assistance with entitlements.
Mid-Shore (Caroline, Dorchester, Kent, Queen Anne's, and Talbot Counties)	Mid-Shore Mental Health Systems, Inc.	\$52,624	80	MIDSHORE MENTAL HEALTH SYSTEMS, INC. – Contracts with vendors to provide homeless outreach to all five counties, assessments, housing security deposits assistance, case management, conduct needs assessment, one time only rental payments.

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SERVICE AREA OF PROJECT	ADMINISTRATIVE ENTITY	PATH SFY 2011 FUNDING	PROJ. # SERVD. SFY 2011	SERVICES PROVIDED UNDER PATH
Montgomery County	Montgomery County CSA	\$115,588	300	MONTGOMERY COUNTY DETENTION CENTER- Outreach, engagement, linkage to mental health and co-occurring treatment services, case management, and housing assistance.
				VOLUNTEERS OF AMERICA- Outreach on streets, at emergency shelters, day programs, soup kitchens and to those on the psychiatric crisis intervention unit, case management and linkages to entitlements and services.
Prince George's County	Department of Family Services, Mental Health Authority Division	\$119,264	140	QUALITY CARE INTERNET BEHAVIORAL HEALTH – Outreach, screening, assessment, case management, supportive services in residential settings, housing assistance, referrals to mental health services, medical, housing, rehabilitation, and vocational training, one time only rental assistance and security deposits. Prince George's County Department of Social Services or selected vendor will target Thirty (30) individuals and assist them with completing SSI/SSDI applications based on technical assistance and training provided by SOAR Outreach Specialist.
Somerset County	Somerset County CSA	\$10,000	6	SOMERSET COUNTY CORE SERVICE AGENCY-Outreach, housing services, i.e. one time only rental assistance to prevent eviction, security deposits, planning of housing, and minor renovations to existing housing.
St. Mary's County	St. Mary's Department of Human Services	\$45,950	120	DETENTION CENTER MENTAL HEALTH - to serve homeless, detention center inmates with mental illness, screening, assessment, linkage to community resources. Two hours per week of telepsychiatry in a mental health clinic to assist with aftercare planning.
				THREE OAKS SHELTER – Outreach and case management services and aftercare which includes housing are its goals.

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SERVICE AREA OF PROJECT	ADMINISTRATIVE ENTITY	PATH SFY 2011 FUNDING	PROJ. # SERVD. SFY 2011	SERVICES PROVIDED UNDER PATH
Washington County	Washington County CSA	\$37,000	350	TURNING POINT – Case management outreach, job training, supportive and supervisory services, screening and diagnostic services. 2 positions: homeless outreach worker and outreach assistance.
Wicomico County	Wicomico County CSA	\$22,000	40	WICOMICO COUNTY CSA- Assessment, service planning, linkage to mental health, housing, medical, employment, outreach, and case management.
Worcester County	Worcester County CSA	\$33,281	35	HEALTH DEPARTMENT – MENTAL HEALTH PROGRAM – Mobile assessments, assertive outreach, training one - time only rental payments, security deposits, minor renovation, expansion and repair of homes, mental health and case management.
TOTAL Maryland	24 Jurisdictions	\$1,287,000	2,402	

As in previous years, data on the number of persons served included those served through outreach and those receiving ongoing PATH services. Due to changes in definition, PATH consumers who are engaged through outreach are no longer included in the number of persons to be served. PATH providers are currently counting only those who are considered enrolled (client file opened and service plan developed) as the number served in FY 2010.

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In 1995, the U.S. Department of Housing and Urban Development (HUD) first awarded MHA a five-year, \$5.5 million Shelter Plus Care grant to provide housing for individuals who are homeless with serious mental illnesses and their dependents who are being released from the detention center, or are in the community on intensive caseloads of parole and probation. Last year, the FY 2010 Shelter Plus Care Housing grant was renewed for \$3,820,578 for 22 Shelter Plus Care renewal grants.

For FY 2011, MHA was awarded funding in the total amount of \$4,529,532 for the Shelter Plus Care renewal grants. The renewal grant award was increased largely due to increases in the Fair Market Rental Values, increases in the number of units funded by HUD, and the renewal of all five-year grants. Currently, MHA is serving a total of 599 persons, 137 single individuals with mental illness, 165 families with 283 children and 14 other family members through all of the Shelter Plus Care grant programs.

Since 1995, the process for applying for funding through the U.S. Department of Housing and Urban Development (HUD) has changed. In 1996, HUD introduced communities to the Continuum of Care model to strategically address the problems of housing and homelessness in a more coordinated and comprehensive fashion. The model required local communities to develop a strategic plan to address the use of HUD resources and this also became the application process for obtaining HUD funding. As a result of this change, MHA lost its ability to directly apply for Shelter Plus Care Housing grant funds to HUD and to apply for funding using a single statewide application. The new process requires MHA and other state and local entities to apply for funding through the local Continuum of Care Planning group. In FY 2010, MHA submitted 22 renewal grants to thirteen Continuum of Care Planning groups as a part of their application for HUD funding. Each local Continuum of Care of Plan must incorporate MHA's Shelter Plus Care application into its local plan annually.

Advocates for the homeless and for housing for people with disabilities in Maryland have expressed concern with proposed changes in the Housing Choice Voucher Program. If fewer vouchers are available for individuals with disabilities, then it will be more difficult to advance consumers from Shelter Plus Care to other housing choice programs.

Individuals who are homeless are also served by traditional mental health treatment and support programs, including existing psychiatric rehabilitation programs, case management entities, crisis service providers, and mobile and on-site clinic services. In addition, outreach and eviction prevention services, as well as coordination with needed mental health services are provided to homeless individuals. In Baltimore City, Baltimore Mental Health Systems, Inc. obtained grant funds to provide case management and other services for homeless individuals with mental illnesses. State general funds and mental health block grant funds support additional services and programs for the homeless population.

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MHA provides state general funds to support statewide training for mental health providers, which includes providers of PATH services. A portion of Baltimore Mental Health Systems PATH funding is targeted for training for PATH staff delivering services to PATH eligible consumers. In addition to formal training, MHA have quarterly meetings with PATH providers to discuss clinical and programmatic issues and to provide an opportunity for information sharing between local providers.

In SFY 2010, MHA's Office of Special Needs Populations sponsored several trainings and a conference. The Office sponsored five 2-day Stepping Stones to Recovery SOAR trainings in collaboration with the University of Maryland Training Center using state general funding and PATH funding.

The 2-day SOAR trainings provided an in-depth, step by step explanation of the SSI/SSDI application and disability determination process and provided strategies for case managers working with homeless persons with serious mental illness and co-occurring substance use disorder to successfully access SSI/SSDI benefits. A total of 166 people were trained through these five 2-day trainings.

In addition to SOAR, the Office of Special Needs Populations/Behavioral Health Disaster Services (BHDS), in collaboration with the Office of Consumer Affairs, provided 3 regional disaster preparedness seminars in April 2010. The training seminars addressed, among other things, consumer questions and concerns as expressed in a recent survey to On Our Own chapters across Maryland. Each regional session was three hours in length and was designed to promote audience participation and to generate sustainable action plans for Wellness & Recovery Centers with regard to disaster preparedness, response, recovery and mitigation. Agencies who attended included Wellness and Recovery Center directors, board members and consumers, local NAMI representatives and Core Service Agency (CSA) personnel. A total of 54 individuals attended and are now able to provide local trainings to staff and consumers. These trainings were held on April 8, 2010 in the Eastern Shore region, April 12, 2010 in the Western region, and on April 21, 2010 in the Southern region.

On June 18, 2010, MHA's Office of Special Needs Populations co-sponsored the Thirteenth Annual Symposium on Mental Disability and the Law along with the Office of Forensics Services and the University of Maryland Mental Health Training Center. As a part of this symposium, training was provided for trauma specialist on the Trauma, Addictions, Mental Health, and Recovery (TAMAR) treatment model.

Another essential task which supports the trainings includes technical assistance to counties with implementing SOAR and incorporating SOAR critical components into existing PATH services. With technical assistance from the National SOAR Technical Assistance Center at Policy Research Associates, the Director of the Office of Special Needs Populations (SOAR Team Leader for MD) met with Anne Arundel County, Baltimore County, Frederick County, eight of the Eastern Shore counties which consist of: Caroline, Dorchester, Kent, Queen Anne, Somerset, Talbot, Wicomico, and

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Worcester; and Montgomery County to implement a SOAR initiative in their local jurisdictions. In November 2009, Anne Arundel County launched their SOAR initiative. In June 2010, the Lower Eastern Shore counties of Somerset, Wicomico, and Worcester launched a SOAR initiative. In September 2010, Howard and Montgomery counties' SOAR initiative will be launched.

MHA's Office of Special Needs Populations will continue to meet with other jurisdictions to expand SOAR and PATH services statewide during FY 2011. MHA's Office of Special Needs Populations will be meeting with Carroll County Core Service Agency (CSA) and several providers that serve persons who are homeless to develop a SOAR work plan and to implement the SOAR initiative in Carroll County. Finally, MHA will continue to be involved in the HUD Continuum of Care process to access funding and partner with local agencies to expand service and housing opportunities for persons who are homeless and have a mental illness.

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SFY 2011 OBJECTIVES FOR CRITERION 4:

SERVICES FOR ADULTS

TARGETED SERVICES TO THE HOMELESS

- Utilize Projects for Assistance in Transition from Homelessness (PATH) funding and the SSI/SSDI Outreach, Access, and Recovery (SOAR) Initiative mechanisms for outreach, the prevention of homelessness, and the promotion of recovery for individuals who have mental illnesses.
MHA Monitor: Marian Bland and Keenan Jones, MHA Office of Special Needs Populations
- Maximize use of the Shelter Plus Care Housing funding, and other support systems to provide rental assistance to individuals with mental illnesses who are homeless, or were formerly homeless, using federal Department of Housing and Urban Development (HUD) funding.
MHA Monitor: Marian Bland and Keenan Jones, MHA Office of Special Needs Populations

TARGETED SERVICES TO OLDER ADULTS

During FY 2010, approximately 1,040 persons aged 65 and older were served through the PMHS fee-for-service system. Services rendered included case management, crisis, inpatient, mobile treatment, outpatient, inpatient, psychiatric rehabilitation, residential rehabilitation, respite care, and supported employment. Older adults access services in the PMHS in the same way as other age groups. Access to outpatient services can be challenging due to the reduced fees paid by Medicare. Providers are, at times, reluctant to provide this service to large numbers of Medicare recipients. The PMHS also provides non-Medicare covered services to older adults who meet the eligibility and medical necessity criteria for the service.

In addition to these services in the fee-for-service system, MHA funds specialized services for older adults through the CSAs. Since 1988, MHA has utilized a team of psycho-geriatric nurse specialists and social workers to provide consultation services to nursing homes and community programs which serve older adults with mental illnesses. These positions are mentored by MHA's geropsychiatric nurse specialist in their efforts to support older adults with psychiatric disabilities maintain and improve their quality of life. The goal is to continuously increase the knowledge base and skills of community providers in managing the somatic and psychiatric needs of older adults. MHA's Coordinator of Services to Older Adults, MHA's R.N. consultant, and the local consultants are each affiliated with the Maryland Gerontological Association as well as the Mental Health Association of Maryland's "Coalition on Mental Health and Aging". The Coalition's meetings are a vehicle to share information from the local, state, and national levels regarding policies, procedures, regulations, and legislation that affect older adults. Embedded within the Coalition is a State level interagency group with representatives from the Department of Human Services, the Maryland Department on Aging (MDoA), and the Mental Hygiene Administration. In addition, on the local level, this group is joined by representatives from the MHA's Core Service Agencies, the local Areas on Aging, and the local Departments of Social Services. This collective group collaborates on conference planning for older adults, trainings, and strategic planning as well as consultation regarding other issues pertinent to older adults. The Coalition produced a resource guide titled, "Mental Health in Later Life: A Guidebook for Older Marylanders and the People Who Care for Them," and this guidebook continues to be widely distributed throughout the State. MHA's Coordinator of Services to Older Adults continues to work closely with the National Association of State Mental Health Program Directors' (NASMHPD's) Older Persons Division by participating in the monthly conference calls, through volunteering on various committees, and through attending the division's annual meetings. [NFC 4]

MHA contracts with CSAs to fund MHA residential rehabilitation programs in Anne Arundel County, Prince George's County, and Baltimore City to provide nursing services and additional supports for residents of all ages who experience complex somatic and psychiatric conditions. Approximately 150 persons were served through these programs. Additional programs funded by MHA, through the CSAs, include outreach to older adults residing in public housing in Baltimore City; outreach to older adults in Baltimore, Howard, Montgomery, Prince Georges, Calvert, Frederick, Worcester, and

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Garrett counties. Additional MHA funded services that older adult individuals may access include mobile crisis teams, client support, peer support, and emergency psychiatric services. CSAs participate with other county agencies in sponsoring additional specific services. The list below provides some highlights on these MHA funded/CSA sponsored programs:

- **Baltimore City:**

The Psychogeriatric Assessment, Treatment in City Housing program (PATCH)-sponsored by the Johns Hopkins and Bayview Hospitals is an outreach program available to older adults with serious mental illnesses, residing in East Baltimore City “high-rise” housing developments at 17 sites. PATCH offers an alternative for older adults unable to access traditional outpatient treatment services, including medication management and assessments. During FY2010, approximately 85 persons were served through this program.

The Senior Outreach Services (SOS) program-sponsored by the University of Maryland Medical Systems, is an outreach program similar to the PATCH program available to older adults with serious mental illness (SMI), throughout Baltimore City neighborhoods not covered through the PATCH program. In the year 2010, approximately 55 persons were served under this program.

The Harford –Belair Out-Patient Mental Health Center staffs a part-time geriatric psychiatrist and geriatric psychotherapist to serve older adults with mental illnesses in the Harford/Belair Road catchment area of Baltimore City.

The “Glenmore Home” is a specialized Residential Rehabilitation Program serving 8 older adults with complex medical and psychiatric needs. In addition to specialized programming for this population, the program provides 24 hour 7 days per week psychiatric geriatric nursing services.

- **Baltimore County:**

The Peers program offered peer support for older adults with mental illnesses and served approximately 60 persons in FY 2010. Services include “face-to-face” visits and telephone support. The Geriatric Services Team (GST) provided outreach and clinical intervention to approximately 150 older adults, both in the office and in the individual’s home during 2010.

- **Garrett County:**

The Older Adult Transition Service (OATS) provides outreach services, counseling services, information and referral services to persons transitioning from adult to older adult status. Approximately 90 persons were served in the year 2010.

Partnership for Optimal Aging is an interagency committee on aging and health planning that includes representatives of key agencies in Garrett County which serve older adults with mental illnesses.

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- Montgomery County:

Montgomery county provides a “Senior Outreach Program;” “Hispanic Outreach Program, that includes outreach to older adults;” “Hoarding Task Force” that has added a ‘Train the Trainer’ component in order to expand the service; “Prevention Group” located in the “PRPs”, and a “Suicide Policy Workgroup.” Approximately 754 older adults are served through these programs.

- Howard County:

In Howard County, the CSA implemented Healthy IDEAS (Identifying Depression, Empowering Activities for Seniors), a national model. The CSA also coordinated with the local Area on Aging program to provide multiple trainings, and depression screenings in a variety of settings for older adults.

- Worcester County:

Maryland Access Point is a single-point-of-entry program available to all older adults in the county which provides information, referral and access to all countywide services. It is jointly sponsored by the CSA and the local Area on Aging through blended funding from the Department of Social Services and the local Health Department.

Statewide Pre-Admission Screening/Resident Review Program (PASRR).

The statewide PASRR Program is a federally mandated pre-admission screening process for nursing home candidates who are diagnosed with major mental illnesses and whose symptoms have required inpatient psychiatric hospital services within the last two years. The law requires that these individuals be evaluated by an independent review team to ascertain that medical necessity criteria for nursing facility placement is present, that the individual’s continued psychiatric needs can be adequately met outside of an inpatient setting, and that the nursing facility is the least restrictive and most appropriate program to address the individual’s medical needs.

Since the inception of the PASRR program in the 1980's, Maryland continues to see a decrease in the numbers of Level II evaluations submitted to the MHA for review and signature. This is due, in part, to a process that allows for potential PASRR candidates to be evaluated for appropriateness of admission to less restrictive settings at the time of referral for a Level II screen. Additionally, quarterly trainings are provided to nursing facility staff and hospital staff by the PASRR reviewers regarding the criteria necessary for a person to require a Level II evaluation. Intense efforts are made to divert persons from nursing home placement and toward alternative settings. There is no data collected by MHA regarding the number of persons who are diverted from requiring Level II evaluations, as the “Level I “ID screens” are not submitted to MHA. MHA becomes involved at the point when the “Level II “ID screens” are submitted to MHA for review and final sign-off.

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MHA maintains information for PASRR candidates regarding dispositions. For FY 2010, a total of 713 Level II PASRR evaluations were completed and reviewed by the MHA. Of that number, 15 persons were found to not meet the criteria for Level II screens and were therefore, exempted from continuation of the process, and five records remained incomplete in that additional information requested to continue the process was not produced. Statistics for FY 2010 show that approximately 70 persons required more than the initial PASRR evaluation (multiple Resident Reviews) to ensure that nursing home remained the most appropriate setting for them; while remaining persons received only one PASRR evaluation for the year. Of the remaining persons evaluated, 419 were persons over the age of 55, with all persons meeting the definition for eligibility for nursing facility services found in the recently revised Maryland COMAR 10.09.11 "Nursing Facility Services" regulation and the federal PASRR regulations. Maryland's "Medical Necessity Criteria for Nursing Facility Services" was modified as of July 1, 2008, due to a class action suit filed by the Maryland Legal Aid Bureau and the Legal Division of the American Association of Retired Persons (AARP). As a result of these legal changes, additional persons are eligible for admission to nursing facilities. However, some persons were diverted to Medicaid waivers for community alternatives. The remaining persons over age 55 were found to not meet medical necessity criteria and were recommended for community placement.

In FY 2010 training focused on collaborations and partnerships among MHA, MDoA, DDA, and "DHR, as well as the local counterpart to these administrations. In FY 2010, MHA conducted a survey regarding the complexity and extent of somatic conditions facing consumers residing in psychiatric residential treatment programs within the Public Mental Health System. MHTO's geriatric consultant continues to meet with a group of stakeholders to address the extent of issues facing residents in residential rehabilitation programs (RRPs) who are "aging in place." A report identifying the extent of these issues and recommendations is in process.

Maryland's DHMH received a Money Follows the Person Rebalancing demonstration Grant (MFP) from the Centers of Medicare and Medicaid Services (CMS). As part of the implementation of this project to rebalance delivery of long term care services from institutions to the community, and develop transition services, MHA and the Transformation Office worked closely with the Office of Health Services to address the mental health needs of individual waiver participants eligible to transition from institutions into the community, including those persons aged 65+ residing in state psychiatric facilities, and to identify and propose resources within existing Medicaid State Plan services and Medicaid waivers to meet the needs of these individuals. A report was developed integrating plans through a Behavioral Health Committee composed of stakeholders from long term care, mental health, traumatic brain injury, and aging communities, and submitted to the Director of the MFP Program for consideration.

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SFY 2011 OBJECTIVES FOR CRITERION 4:

SERVICES FOR ADULTS

TARGETED SERVICES TO OLDER ADULTS

- MHA, in collaboration with the Committee on “Aging in Place”, will develop an integrated care model for consumers age 50 years and over with behavioral and somatic health needs in PMHS residential programs.
MHA Monitor: James Chambers, MHA Office of Adult Services
- MHA, in collaboration with CSAs and other stakeholders, will continue efforts to address and implement suicide prevention activities for youth, adults, and older adults.
MHA Monitor: Henry Westray, MHA Office of Child and Adolescent Services

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ADULT & CHILD PLAN

CRITERION #5: Management Systems

This Criterion applies to both adult and children and adolescents. It is not duplicated in the Child Plan section.

Mental health transformation efforts and activities in the state are described within the narrative for each criterion and then referenced to the specific goal(s) in the New Freedom Commission (NFC) Reports.

FUNDING FOR MENTAL HEALTH SERVICES

The MHA budget currently contains funding (federal Medical Assistance and State general funds) for specialty (or non-primary) mental health services. This includes funding for services traditionally offered by the PMHS such as outpatient clinics and psychiatric rehabilitation, as well as inpatient psychiatric hospitalization, residential treatment center placement, services rendered by individual practitioners, mental health-related Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services, and mental health related laboratory services. Funding for the pharmacy benefit was formally transferred back to the Medical Assistance budget in FY 2001. This change promotes better coordination of care by utilizing the same pharmacy benefits manager for all prescription drugs. [NFC 4]

In FY 2011 a total of \$978.2 million has been appropriated for the MHA. Of this amount, \$713.7 million (\$599.4 million MA service funds) is for community services, \$256.4 million for State-operated institutions and \$8.0 million for program administration. (Seventy-two point nine percent (72.9%) of the FY 2011 funds are targeted for community services). Several local jurisdictions contribute mental health funding, which is not included in these budget numbers. In addition, MHA continues to contract directly with CSAs to support those programs that provide specialized services that are either not included in the standard benefit package or do not lend themselves to payment through the fee-for-service system. This consists of approximately \$51 million in State general funds and \$27.9 million in federal funds. Federal grants include: this block grant, PATH, Shelter Plus Care, Data Infrastructure Grant (DIG), the Mental Health Transformation-State Incentive Grant, the new multi-year System of Care grant for children and other CMHS and CMS grants.

Vendors are reimbursed for pre-authorized services using a fee-for-service system based on a mental health benefits package. This package is the same for MA 1115 Waiver Medicaid recipients, for non-waiver Medicaid eligible recipients, and for those individuals who, because of the severity of their illness and their financial need, qualify for State subsidized services. Medicaid is the most significant insurance coverage type for consumers in the public mental health system. Medicaid covers 80% of all consumers receiving fee-for-service reimbursement. In recent years Maryland has worked to expand Medicaid eligibility through a number of special initiatives.

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Eligibility requirements for uninsured/MA ineligible individuals to qualify for State subsidized services in the fee-for-service system include uninsured consumers that have received services in the prior two years. Individuals discharged from psychiatric facilities or released from incarceration within the prior three months, on conditional release from a State hospital, who receive SSDI due to psychiatric impairment, or who are homeless do not have to meet these eligibility requirements. In addition, individuals presenting with an urgent need may obtain services upon approval of the appropriate CSA. Many previously uninsured individuals were enrolled in the Primary Adult Care waiver and now have Medical Assistance coverage for most mental health care (excluding hospital emergency, inpatient and outpatient hospital-based services).

In FY 2010, as a result budget reductions, changes to the facilities occurred. In October 2009, MHA closed Walter P. Carter Center, an acute care State facility in Baltimore City. The functions for the inpatient services moved to Spring Grove Hospital Center. In February 2010, Upper Shore Community Mental Health Center was closed. Services shifted to the community with an infusion of funding allowing the Eastern Shore community providers to further develop and implement the types of services required and to expand options beyond traditional hospitalization are for adults. One of these facilities has inpatient units for adolescents, and one offers services for individuals who are deaf and hard of hearing. In addition, MHA operates one psychiatric forensic facility and two residential treatment facilities for youth. The Administration also collaborates with the Maryland Psychiatric Research Center, which is operated by the University of Maryland and is located on the grounds of a major State hospital. This facility coordinates with State facilities and community hospitals to provide innovative research in new medications and treatments for individuals whose mental health symptoms have not been relieved by traditional medication regimens. The Center also conducts physiological research regarding schizophrenia and other psychoses. [NFC 5]

In recent years, reimbursement for care for the uninsured has been policy concern raised by MHA at the budget hearings. Maryland made progress in addressing access to health care for the uninsured. As a result of legislation, medical coverage is being expanded to more than 100,000 uninsured Marylanders. This Medicaid expansion is one of several measures that assist the State to improve access and “put a dent” in the number of uninsured.

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FINANCIAL DATA

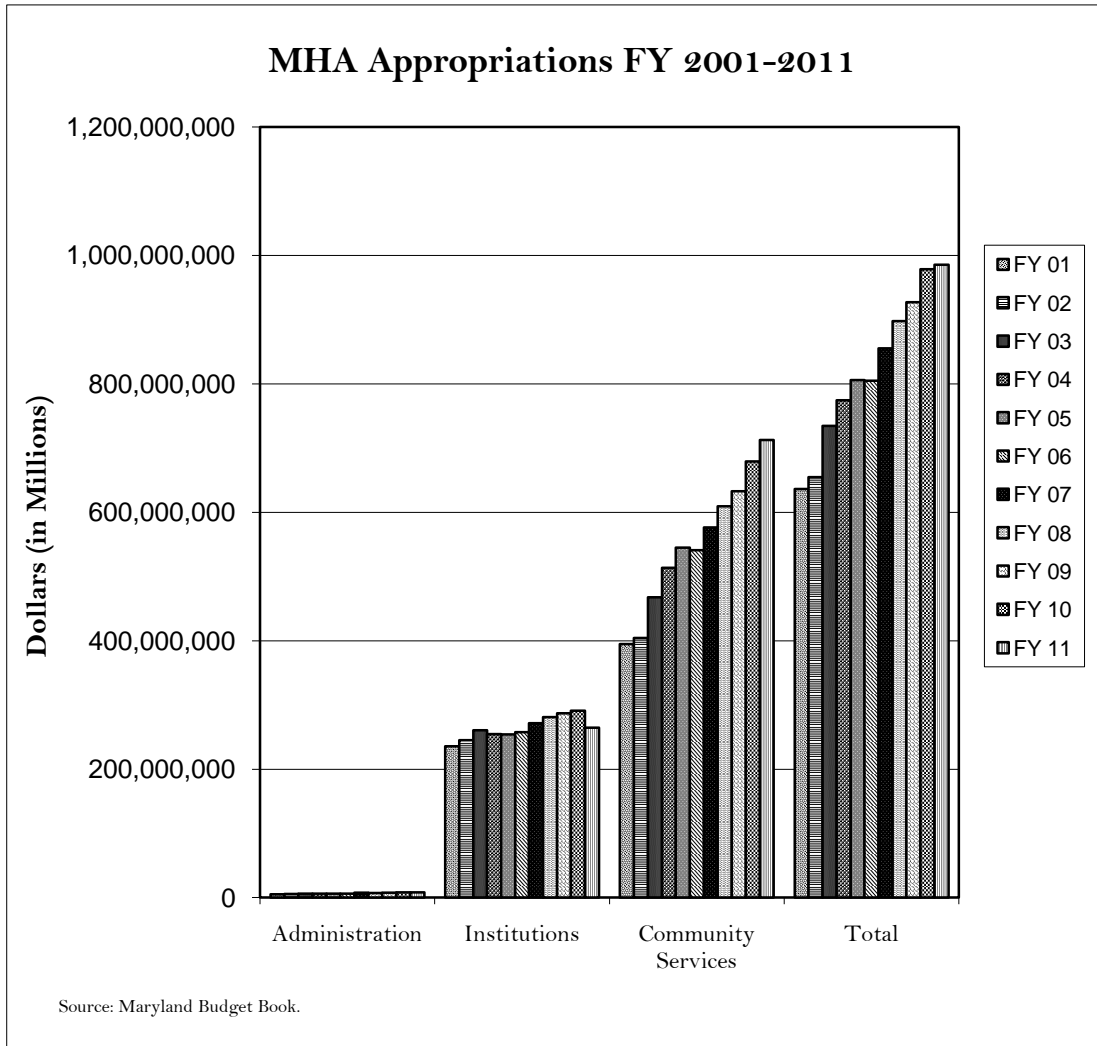
The MHA contracts an administrative services organization (ASO) to assist in the operation of the PMHS. The ASO authorizes services based on medical necessity, processes claims payments, and provides management information services. Data are provided to the MHA, local CSAs, service providers, and the Maryland Medical Assistance program.

Data available from ASO are the source for the community-based fee-for-service information. Data sets are not routinely compiled for those non fee-for-service services that are funded through contracts. Other unavailable data are statistics on services provided to Medicare-only recipients and on Medicare-only reimbursed services. Medicare-eligible services are not subject to authorization and are processed through a federal intermediary, not through the ASO information on individuals that are both Medicare and Medicaid eligible was previously captured by the PMHS. Beginning July 1, 2003, claims for individuals who are qualified for federally matched MA and have Medicare began to be processed by Medical Assistance and the data are no longer in the ASO data system.

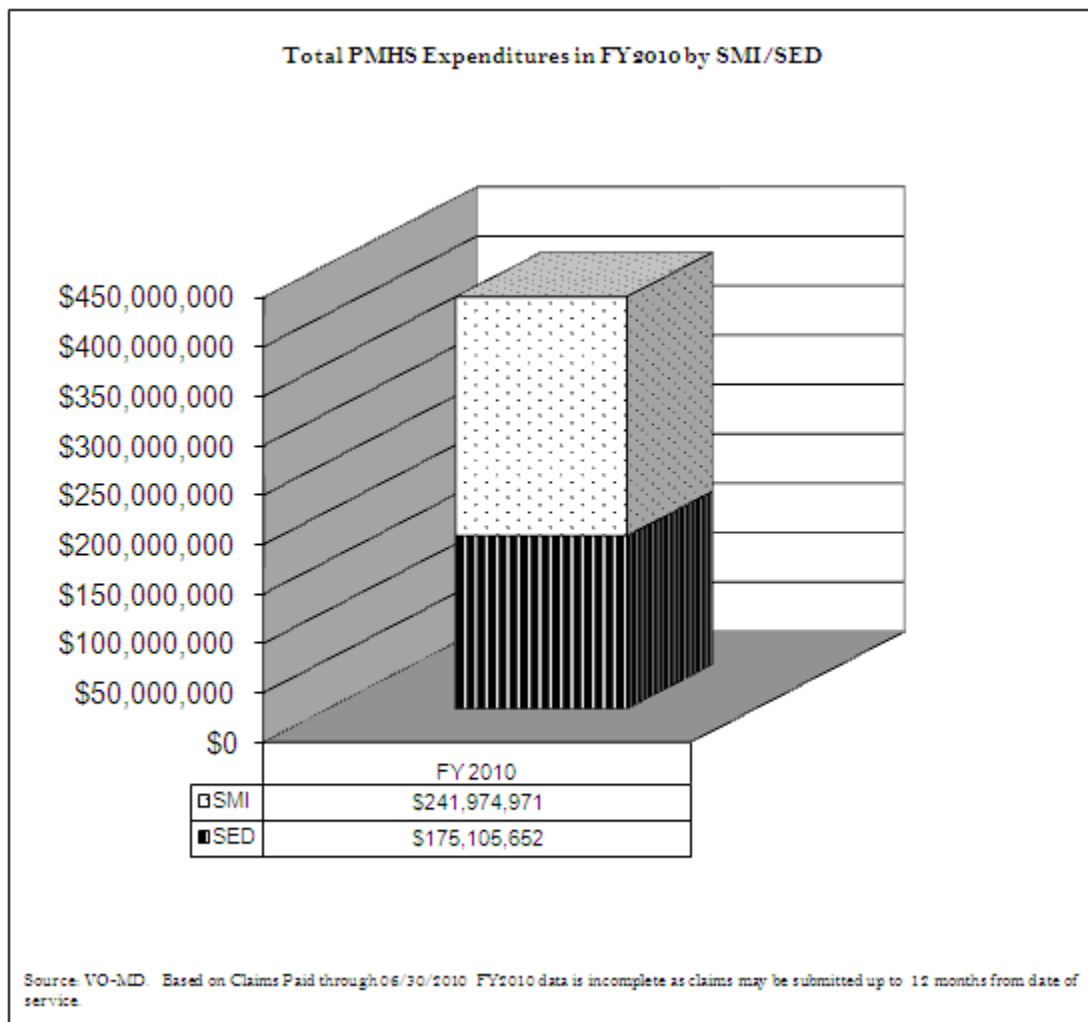
The ASO MIS was utilized to produce most of the data included as performance indicators in this application. Data for FY 2009 are based on claims paid through August 31, 2010, FY 2010 data is projected based on claims paid through June 30, 2010 and historical SMI utilization. Since claims can be submitted up to twelve months following the date of service, the data for FY 2010 is still incomplete. Full year projections were not made for FY 2010. Specific diagnoses were used to define SMI. An individual was categorized as SMI if, at any time during the fiscal year, a diagnosis in the specific categories was submitted on a claim. Due to the transition of the ASO, the PMHS data is currently being processed for validation. Once data is approved for release, information will be updated and adjusted as appropriate performance indicators may change.

The MHA relies on the data from the ASO to monitor the expenditures and federal Medicaid attainments of the PMHS. MHA further analyzes the data for trends in service delivery and/or spending. This information is used to develop strategies for managing the budget, amending current MHA policies as needed, development/implementation of new services, and correcting any problems that may be identified. In addition, the information is used to prepare budgets and budget presentations; to track the number of services and expenditures by consumer age, diagnostic and eligibility categories; and to set rates in subsequent years.

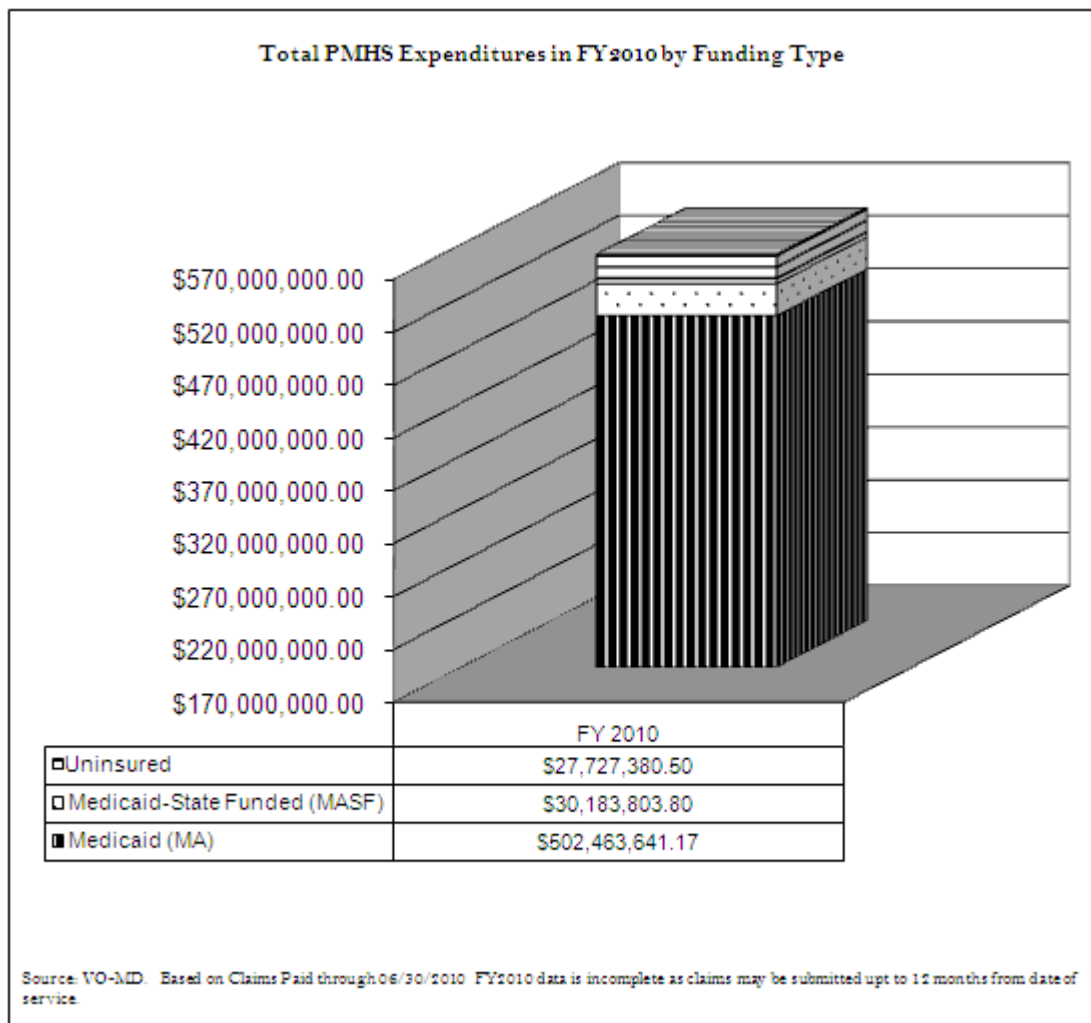
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EVALUATION SERVICES

Several major Evaluation Services endeavors are discussed in this section, including MHA's Outcomes Measurement System (OMS); the Consumer Quality Team (CQT), which is funded in large part through this FBG; the annual Consumer Perception of Care Survey (CPOC); and evaluation projects and activities conducted through MHA's contract with the University of Maryland Systems Evaluation Center (SEC), which is also funded through this FBG.

Maryland's Outcomes Measurement System (OMS), in operation since September 2006, is the result of a collaborative relationship among MHA, the University of Maryland Systems Evaluation Center (SEC), and MHA's Administrative Services Organization (ASO). The OMS was developed to collect information on individuals, ages 6-64, who are receiving outpatient mental health treatment services from outpatient mental health centers (OMHCs), Federally Qualified Health Centers (FQHCs), and hospital-based mental health centers. The OMS questions cover several life domains, including living situation, employment, school attendance, substance use, legal system involvement, symptoms, functioning, etc. The information is collected in order to understand more about the individuals who are receiving services from the PMHS and to begin to understand the outcomes of those services. Information is collected at the beginning of treatment and approximately every 6 months while receiving treatment. In FY 2010, there were several major accomplishments related to OMS: 1) the successful transition of the OMS processes to a new ASO vendor; 2) the continued development and refinement of analytical structures to begin to report client outcomes; 3) the provision of jurisdiction-specific OMS outcome data to the CSAs; and 4) the provision of program-specific OMS outcome data to providers that requested it.

With the change in MHA's ASO vendor, effective September 1, 2009, there were many transition tasks related to OMS, including revising the OMS interview instruments and Interview Guide, and developing detailed specification documents outlining the complex OMS business requirements for the new ASO to implement as part of its service authorization system. In addition to these OMS/ASO transition-related tasks, further development was continued on the analyses of OMS data for individuals, both adults and children/adolescents, who had completed the OMS questionnaire two or more times with the same provider. This involved continuing the refinement of analytical structures for comparing individual consumer progress over time (e.g., definitions for increase, decrease, and maintenance of scores continued to be refined for each OMS life domain). At the individual consumer level, responses from the first OMS interview are compared to responses from the most recent OMS interview and change-over-time scores are calculated. Data is then aggregated to the CSA level and State level. Statewide and CSA level OMS change-over-time analyses were distributed to CSAs in the second half of the fiscal year for continued feedback on the format and utility of the outcome information presented. At the same time, provider-level outcome information was also offered to all OMS providers and distributed to those that requested it (18 providers requested the

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information and a total of 34 location-specific OMS provider reports were generated by the SEC).

The Consumer Quality Team (CQT) initiative, funded in large part through this block grant and launched in FY 2007 through the Maryland Mental Health Association, was another significant evaluation project that was continued in FY 2010. During FY 2010, the CQT conducted 168 site visits to Psychiatric Rehabilitation Programs (PRPs) and inpatient facilities, interviewing approximately 1,000 consumers. The purpose of the interviews is to identify and address specific concerns of individual consumers. At the conclusion of all interviews within a program or facility, the team gives a brief verbal report to the program director or CEO of the facility, resulting in the immediate resolution of many of the identified individual concerns. Monthly feedback meetings regarding the PRP visits are also held with representatives from the appropriate local Core Service Agencies, provider organizations, and MHA. In addition, the leadership staff of CQT meets with the senior management staff of MHA on a quarterly basis to discuss the overall project, issues, trends, etc. While there will be no additional expansion of the CQT project in FY 2011 (due to fiscal constraints), the ultimate goal is offer this initiative in all 24 jurisdictions and the remaining State-operated facilities.

In addition to the above routine activities, CQT began a project to track the 63 consumers who were discharged as a result of the closure of the Upper Shore Hospital Center. Approximately 2/3 of the 63 individuals were interviewed either in-person or by phone, and CQT is working with MHA and the appropriate CSAs to locate and interview the remaining individuals. As a result of this project, CQT expanded its activities into six programs in several jurisdictions on the Eastern Shore.

Two other major activities of the CQT in FY 2010 included:

- 1) Working with the University of Maryland, Systems Evaluation Center to complete a two-year evaluation of the CQT program, with input from consumers, providers, the CQT Feedback Committee, and the CQT Oversight Committee. As a result of this evaluation, CQT made several modifications to its processes to better meet the needs of all the stakeholders. The collaborative efforts of both organizations was seen as exceptional by the American Evaluation Association, and representatives from SEC and CQT made a presentation at the organization's annual conference.
- 2) Ensuring that the consumer's perspective is represented by serving on the following committees: Johns Hopkins Bayview Recovery Centers of Excellence Leadership Council, Sar Levitan Center for Public Policy Workforce initiative, MHA Facilities Recovery Work Group, Maryland Consumer Leadership Council, and Maryland Association of Peer Support Specialists. In working with these committees, CQT has been instrumental in the development of the Peer Employment Specialist Toolkit and the curriculum for the Maryland Peer Support Specialist Certification Program.

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In addition to the two major evaluation initiatives described above, MHA, through its contract with the ASO, continues to conduct annual Consumer Perception of Care (CPOC) surveys via telephone interviews. As with previous survey efforts, the survey tools are based on the most recent versions of the Mental Health Statistics Improvement Project (MHSIP) consumer survey tools for both adults and children and adolescents and their families. The CPOC surveys were conducted in Winter/Spring 2009 with individuals who received outpatient mental health services in 2008 and the analyses of results were completed. An Executive Summary Report and tri-fold pamphlets detailing the results of the survey were prepared and widely disseminated. In order to continue to comply with annual federal URS requirements, the CPOC surveys were conducted again in the third quarter of FY 2010. Through this most recent survey, Maryland has continued to incorporate the relatively new federal reporting requirements for functioning, social connectedness, criminal/juvenile justice involvement, and school performance (i.e., attendance and suspensions/expulsions). Analyses of the current survey results will be completed in FY 2011, and reports and tri-fold brochures will again be generated and distributed. (Information from the CPOC surveys is used to address several MHBG indicators).

Finally, MHA continued to contract during FY 2010 with the Systems Evaluation Center (SEC) within the University of Maryland, School of Medicine, Department of Psychiatry, Center for Mental Health Services Research, Mental Health Systems Improvement Collaborative (MHSIC) for a variety of PMHS evaluation projects and activities. This Center is funded through this block grant. The SEC, now in its ninth year of operation, began its work in August 2001 (FY 2002), and is one of three centers within the MHSIC. The others are the Training Center and the Evidence-Based Practice (EBP) Center. The SEC was created to increase MHA's capacity for a methodical and systematic approach to measuring PMHS performance. Overall goals of the SEC are to design systems/program evaluation questions, methods, and studies; develop analytic structures for more advanced analysis of existing PMHS data; and identify cost-effective practices with positive outcomes for consumers. In doing so, MHA obtains information that enhances its ability to plan, manage, monitor, and evaluate PMHS efficiency and effectiveness.

Highlights of SEC projects and activities during FY 2010 included:

- participating in the OMS activities described above, particularly with respect to the transition of the OMS to a new ASO vendor, refinement of analyses of change-over-time data, and development and dissemination of OMS outcome reports to CSAs and providers;
- completing the OMS feedback project, which heavily informed the OMS modifications that were made during the ASO transition;
- finalizing the process to evaluate the psychometric properties of the OMS questionnaires and beginning implementation of the OMS Validation Study data collection and analyses;
- participating with MHA and the ASO in the process of developing the detailed specifications required to implement the second generation of the OMS data mart, which will include both point-in-time and change-over-time OMS analyses;

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- completing the process evaluation of the CQT initiative described above, including finalizing the report and presenting the results to the CQT Oversight Committee;
- continuing to implement the Data Infrastructure Project (DIP)/PMHS Data Analysis Project, including assisting MHA to complete all basic and developmental Uniform Reporting System (URS) tables; providing significant input for Maryland's DIG application; working with other MHA contractors and the ASO on a variety of ASO transition-related data issues; providing technical assistance and consultation to MHA and the ASO in the areas of rates, Medical Assistance/MMIS, employment network, OMS, CPOC surveys, and URS issues; providing support for the data section of CSA plans and providing data templates for FY 2010 CSA data reporting; providing analysis for an economic evaluation of the Self-Directed Care initiative; and providing analyses of PMHS data in support of several other CSA and MHA projects; and
- continuing to provide supervision, support, technical assistance and consultation for the evaluation component of the Mental Health Transformation State Incentive Grant (MHT SIG), including providing supervision for all MHT SIG evaluation activities; performing management and administrative functions for the MHT SIG contract; continuing to implement the federally required national evaluation Proof of Concept recovery and resilience studies and local evaluation activities; developing a Consumer, Youth, and Family Form with the collaboration of other grantee states to provide evaluation feedback to the MHT SIG staff and national cross-site evaluators; and participating in monthly national conference calls.

During FY 2011, the SEC will be involved with the following evaluation projects and activities:

- Outcomes Management System (OMS) – collaborating with MHA and ASO to complete the tasks necessary to ensure a successful implementation of the second generation of the OMS data mart; continuing to identify and conduct analyses on the OMS data, including analyses with other available databases (e.g., authorization data, claims data, etc.); and continuing to conduct the OMS Validation Project analyses;
- Mental Health Transformation State Infrastructure Grant (MHT SIG) – completing all evaluation activities related to the current MHT SIG;
- Evidence-Based Practice (EBP) Projects – continuing to collaborate with the EBP Center and MHA to provide technical assistance and support related to the evaluation of EBPs;
- Data Infrastructure Project (DIP)/PMHS Data Analysis Project – continuing to provide oversight and assistance in DIG activities, including data analysis support, conducting data seminars, and assisting CSA planning efforts; and
- Other Evaluation Projects – conducting evaluation activities related to the integration of somatic and mental health care service provision; designing and initiating a study of PMHS population dynamics; and providing technical assistance and support related to the evaluation of recovery-related PMHS initiatives.

AVAILABILITY OF HUMAN RESOURCES

MHA recognizes that well-trained staff is a critical component of providing mental health services. Currently, there are 120 outpatient mental health programs and 123 psychiatric rehabilitation programs, many in multiple locations that are not included in this count. In FY 2009, there were 3,091 state hospital and residential treatment center full-time equivalent employees and 84 employees in MHA headquarters. In FY 2010, there were 2,823 budgeted positions in the facilities and 83 in headquarters. In FY 2011, there are 2,816 budgeted positions in facilities and 83 in headquarters.

WORKFORCE DEVELOPMENT

Training and Workforce Development Activities

Training continues to be a priority and primary responsibility of MHA, directly and indirectly through collaborative agreements with the University of Maryland Mental Health Systems Improvement Collaborative (MHSIC) Training Center and the Maryland Child and Adolescent Mental Health Institute. During the past year, training was presented in large and small group settings and through webinars targeted at specific populations or providers. Training included: services to specific age and special needs populations and support of the implementation of a variety of initiatives (e.g. early childhood interventions, older adult issues, trauma sensitive care, etc.). MHA's annual conference, held in May 2010, was titled "Finding Potential in Challenging Times". The keynote speaker was Rosanne Torpey who spoke on "All Stressed Up and Everywhere to Go". Fourteen workshops focused on various aspects of resiliency, hope, leadership and new initiatives in Maryland.

There were two first time events in FY 2010. First was the Adult Services Conference, which combined activities including housing, case management, older adults, traumatic brain injury, and the following evidence based practices: supported employment, family psychoeducation and Assertive Community Treatment. Second was the first skills training initiative offered by MHA. This is a four part training with follow up on motivational interviewing, an evidence based practice taught with adult learning theory emphasizing participant participation with the process. This is a self pay event, and plans are to continue into the next fiscal year. So far, 160 individuals have gone through the training, with two more agencies ready to go in the fall of 2010.

Cultural and Linguistic Competence Initiative. In another approach to advance the Cultural and Linguistic Competence Initiative, MHA and the Mental Health Transformation Office (MHTO), have developed and implemented the Cultural and Linguistic Competence Leadership Academy. This Academy is designed to assist organizations in Maryland with the incorporation of cultural and linguistic competence as an integral aspect in their organizational structure and operation. Implemented as a pilot project, this initiative involves the recruitment and training of individuals who will become "leaders" of change within their specific organizations. The "leadership team"

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includes management and direct care staff representatives and two consumers from each site. The project is under way with a five day training taking place from June 2009 to September 2010 that targets organizational change within the selected provider programs and the collection of data to assess the impact of the training on consumer and program staff perception of cultural competence and the process of consumer recovery. Data analysis, along with the actual training and technical assistance, will support the development of an action plan to be utilized by the participating programs to move services and treatment toward cultural competence.

Other activities that are being provided and are consistent with the training initiative include:

- Technical assistance to organizations throughout the state,
- Workshops and conferences to raise awareness of cultural competence, and
- Utilization of an assessment tool to evaluate consumer and staff perception of cultural competence of providers/programs.

Additionally as a result of Maryland's participation at the National Policy summit on Elimination of Mental Health Disparities. Efforts lead by DHMH's Deputy Secretary for Behavioral Health and Disabilities, are underway to improve workforce diversity and cross training activities the three behavioral health and disability administrations.

Additionally, the Recovery Centers of Excellence Project (RCEP) is a major statewide project intended to create culture change within four community mental health programs, as they embrace and operationalize the concepts of recovery. The MHTO is funding this activity. On Our Own of Maryland (OOOMD), a statewide consumer organization, is overseeing this project as part of their Recovery Training Institute. A Request for Expressions of Interest was used to select the four agencies for their participation in this yearlong project. OOOMD is providing the agencies with formal training, consultation, technical assistance and guidance from skilled trainers in multiple core competencies related to the concepts and implementation of recovery in mental health services. Subject matter experts include local as well as nationally known experts in the field. At the conclusion of the project, the agencies will be designated as Centers of Excellence in Recovery, and will mentor additional agencies.

In Maryland, activities related to the workforce development break into several areas with clusters of activities focused on adults with mental illnesses and other activities directed towards children and adolescents with serious emotional disturbance (SED). In this Criterion 5, we will discuss sub-areas of workforce and training issues including each target group separately as appropriate.

Workforce Development and Education, and Other Workforce issues such as Recruitment, Retention and Compensation – Adult, Child and Adolescent

Maryland residents with mental illness will benefit from services from a strengthened mental health workforce, with the ongoing mission of eliminating stigma. Through the creation of strategies to address mental health workforce needs, issues such

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as recruitment, training, retention, and diversity will be addressed. Maryland's Mental Health Transformation Office (MHTO), working with the Governor's Workforce Investment Board (GWIB), Community Behavioral Health Associates, and Johns Hopkins University's Sar Levitan Center, produced a workforce pipeline study in FY 2010 with recommendations to make effective and permanent changes in this area. As a result of this study, a pilot program was developed in conjunction with Anne Arundel Community College and the Community Colleges of Baltimore County. This pilot established a certificate program for direct care workers in the PMHS. The certificate program in turn feeds into an AA degree in behavioral health. Because community college tuition rates subsidize the cost of the training and GWIB has agreed to contribute resources, providers are able to pay higher rates to entry level workers participating in the program. The workgroup is also collaborating with MCLC to develop One-Stop Employment Centers targeted specifically to the needs of consumers of mental health services and located at the Wellness and Recovery Centers.

MHA also funds the Maxie Collier Scholars Program (MCSP) in which minority undergraduate students are provided with stipends and mentoring to encourage them to pursue graduate education towards a career in mental health. The undergraduate disciplines participating include nursing, natural sciences (pre-med), psychology, and social work. During academic year 2009-2010, eight students were enrolled as scholars in the MCSP. The program sponsors a mental health seminar entitled: "Emerging Issues in Mental Health and Well-being," which meets a general education requirement and is open to all students. Other program elements include: an internship in a mental health setting; access to a network of career placement resources; general academic advisement; individualized graduate school preparation and support plan for each scholar; and enrichment activities, i.e. mental health seminars, workshops, and conferences.

In an effort to address the increasing need for qualified professionals and paraprofessionals to serve children with mental health needs and their families, DHMH in collaboration with the Maryland State Department of Education (MSDE) convenes the Maryland's Child and Adolescent Mental Health Workforce Development Steering Committee. It is comprised of 50 members and includes consumers, families, trainees, state and local agencies, representatives of higher education, public and nonpublic schools, and providers of services. MHA's Director of the Office of Child and Adolescent Services co-chairs the committee with the Deputy State Superintendent for Special Education of MSDE. The committee strives to assist in the development of core competencies, strategies and recommendations to assure the efforts to address recruitment and retention issues, quality training of children's mental health workforce, a uniformity of Maryland standards across equivalent training programs, and effective credentialing of children's mental health providers in the State. A set of core competencies in child and adolescent mental health have been developed to be utilized in Web-based curricula and in the classrooms of Maryland colleges and universities. These curricula are also being used for continuing education and in-service training for the existing workforce. A number of specialized curricula have been developed and will be offered in Web-based formats in undergraduate and graduate programs and for continuing education units in upcoming years.

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An interesting example is the Maryland Early Childhood Certificate program. This program is a series of Web based and seminar-related coursework, open to post-masters degree students, offering a concentration in Early Childhood Mental Health. This certificate program is offered by the Center for Infant Study at the University of Maryland through the Maryland Child and Adolescent Mental Health Institute. At the end of the most recent academic year, a total of 96 child-serving professionals had received a certificate in early childhood mental health since the inception of the program several years ago, greatly assisting in the process of expanding early childhood mental health programs in day care and early childhood education settings as described in other criteria.

Similarly, MHA has partnered with the Maryland Association of Resources for Youth (MARFY), the state's child services provider association, to create a certificate program at the associate degree level for paraprofessional child care services in conjunction with community colleges around the state. The Child and Youth Care Certificate Program (CYCP) is an eight course, twenty-five credit program which began enrolling students during the fall 2007 semester. Enrollment at four different course locations, two satellite locations, and in one on-line course since inception of the program has numbered at least 79 (possible duplicate count of actual students). To further statewide applicability the program will submit a request for "statewide" designation that will allow students residing in all of Maryland's jurisdictions to benefit from in-county tuition rates. Tuition from the courses will sustain this project. Eventually, all residential child care facilities in the state will require credentialed staff with this or equivalent training.

Maryland through the Center on the Social Emotional Foundations for Early Learning (CSEFEL) is participating in a training and technical assistance project to foster the professional development of the early care and education workforce. The Maryland State Department of Education and the MHA are jointly sponsoring this project. CSEFEL works with Maryland to accomplish the following goals: convene a collaborative workgroup to develop policies that sustain the model; train trainers and coaches to build the capacity of the workforce and support local implementation; supports 4 local programs to serve as demonstration sites; and evaluate outcomes.

Training in Maryland is facilitated by strong public-academic partnerships. Executive staff at MHA and university leaders collaborate regularly on system and program development. Since the 1970's, the Maryland Plan, a program for training and recruitment of psychiatrists into the public sector, has been in place between MHA and the University of Maryland School of Medicine. Other professional schools (nursing, social work, psychology, and rehabilitation) at the university campuses have been involved as well. Additionally, a collaborative program for training child psychiatrists is in place between MHA and Georgetown University. The University of Maryland and Johns Hopkins Department of Psychiatry and the Georgetown University are partners with MHA in the planning and development of child and adolescent services, providing regular technical assistance and consultation.

EVIDENCE BASED PRACTICES

Adult

The mental health field has benefited from a substantial body of research about practices that can improve the lives of many people who experience mental illness. The Mental Health Systems Improvement Collaborative (MHSIC) was created in 2001 as a joint venture between the Mental Hygiene Administration (MHA) and the University of Maryland, Baltimore (UMB). MHSIC is located in the Division of Services Research, which is a unit of the School of Medicine's Department of Psychiatry. MHSIC is made up of the Mental Health Services Training Center, the Evidence-Based Practice Center (EBPC) and the Systems Evaluation Center (SEC). Through the block grant, MHA funds the EBPC and the SEC at the MHSIC. These three Centers work in partnership with MHA to foster and support the continued development of the Public Mental Health System (PMHS). The combination of Centers provides an opportunity to initiate changes in system management, policy development, and service delivery while assessing and analyzing system performance.

The EBPC is in the eighth year of active implementation of Evidence-Based Practices (EBPs) for adults. These include Supported Employment (SE), Assertive Community Treatment (ACT) and Family Psychoeducation (FPE). Additionally a Co-Occurring Disorders Specialist is working to move the system towards Dual Diagnosis Capability, and is also monitoring the activities of two programs implementing Integrated Dual Disorders Treatment. Fidelity assessments for programs offering the EBPs of ACT, FPE and SE are conducted by MHA Fidelity Monitors annually to determine a program's eligibility to receive the enhanced EBP reimbursement rate. Sites must score a minimum of 4.0 on the fidelity measurement tool, taken from the SAMHSA toolkit, in order to bill at the enhanced rate. Following is a discussion of the EBP Center's current year's activities.

There are 17 Evidence-based Practice Supported Employment (EBP SE) programs currently meeting high fidelity; an additional 18 have been or are being trained on this practice but have not met the fidelity threshold. Following initial training, ongoing on-site technical assistance as well as semi-annual "booster sessions" are offered to all the programs. Additionally, 30 to 60 days prior to each program's next scheduled fidelity assessment, an on-site visit is held, to identify any drift from the model and to help the program take corrective measures. After the assessment, the SE Trainer develops a Fidelity Action Plan to address identified areas which may need improvement. In addition to work with the SE programs, a continuing initiative has been the SE Trainer's work with the SE Specialists on ACT teams, to train them in the EBP principles of supported employment and improve consumer employment outcomes. Finally, the SE Trainer has been invited to participate in the Psychiatric Specialist Group in the Division of Rehabilitation Services (DORS) within the Maryland State Department of Education. The objective of this group is to bring together counselors from DORS, Addictions and Mental Health for networking, training, problem solving, and general

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discussion. These meetings take place on a quarterly basis. Regarding SE data collection, Maryland collects the same program level information currently being collected by Dartmouth for all SE programs across the country, and also documents the successful closures (indicating a consumer has been in a competitive employment job for 90 days) from the Division of Rehabilitation Services for each program. This information is then put into graphs and returned to the programs with their fidelity assessment reports, allowing them to monitor and chart their progress across both process and outcome domains.

Maryland currently has 10 Assertive Community Treatment (ACT) teams, serving over 1600 consumers. These ACT teams provide intensive, mobile, assertive mental health treatment for people for whom traditional mental health services do not work, and they do so with a model of strong evidence of effectiveness. Training, consultation and technical assistance on ACT continue to be provided either directly by the ACT Trainer or by two high fidelity ACT programs which serve as the state's Training Resource Programs. The TRPs provide these activities under a contract with the UMD Evidence Based Practice Center (EBPC) and under the supervision of the ACT Trainer. In an attempt to provide specialized training and support to the Substance Abuse and Supported Employment Specialists on ACT teams, the ACT Trainer organized multiple focus groups for all teams to discuss their needs around substance abuse interventions and vocational issues. The ACT Trainer then helped to establish a training program for all sites with assistance from the Trainers for Supported Employment and Co-occurring Disorders (COD). The EBPC Trainers on ACT and COD are working together to develop an specialized training for each ACT team to achieve increased substance abuse intervention capability.

Evidence-based Family Psychoeducation (FPE) is actively being offered in three agencies. Two more agencies are beginning their implementation efforts with the help of the FPE Trainer. Training, consultation and technical assistance are provided to the programs in a manner similar to that described above for the SE Trainer. Additionally, bi-monthly technical assistance calls are facilitated by the FPE Trainer and a staff person from MHA. Strategies for outreach and practical suggestions for difficult clinical situations that arise are often the focus of these calls, which offer an opportunity for creating a peer supervision and informal problem solving process across programs providing this EBP.

Maryland continues efforts in the implementation of practices related to co-occurring disorders within the public mental health system (PMHS). The Co-occurring Disorders Trainer provides consultation and technical assistance on system change models such as the Comprehensive, Continuous, Integrated System of Care (CCISC) model, developed by Ken Minkoff, M.D and Christie Cline, M.D.. Each jurisdiction is unique, and requires specialized consultation geared to its progress in implementing a system change effort. The counties remain in various stages of implementation. The COD trainer is also working with two agencies in Maryland on the implementation of the Integrated Dual Disorders Treatment (IDDT) EBP. He works with agency leaders and a consultant from the New Hampshire-Dartmouth Psychiatric Research Center to provide

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technical assistance and monitor progress of implementation, and is able to advise MHA on system barriers and facilitators within Maryland for this EBP. Additionally, under an initiative out of the office of the Deputy Secretary of Behavioral Health and Disabilities (which includes the Alcohol and Drug Abuse Administration (ADAA), the Developmental Disabilities Administration (DDA), and MHA), the COD Trainer also participates in a MHA/DDA/ADAA workgroup to establish statewide competencies for Co-occurring Disorders. This workgroup has reviewed and selected for implementation an existing curriculum, modified it to fit Maryland's system, and has established a statewide training process which brings together supervisors from all of the three administrations in a cross-training initiative.

In FY 2011 the COD Trainer will be meeting with each Core Service Agency Director to discuss best ways to achieve dual diagnosis capability for their providers, as well as how to align services to ensure coordinated care for the co-occurring population. Maryland will focus on the goal of becoming dual diagnosis capable rather than pursue the adoption of any one specific model at this time.

Child & Adolescent

The Maryland Child and Adolescent Mental Health Institute/ Innovations Institute—known as the Institute, has been described at length in earlier criteria and serves as the principal training arm of the child and adolescent mental health system. Now funded by both MHA and the Children's Cabinet, the Institute provides training on system of care principles and on the delivery of high fidelity Wraparound services. In addition, the Institute provides training that certifies providers of family to family and youth to youth peer support under the 1915 (c) waiver. The System of Care Training Institutes are held annually each year.

The Institute is helping in the implementation of several Evidence Based Practices including Trauma Informed Cognitive Behavioral Therapy. In conjunction with the Children's Cabinet, the Institute is overseeing the implementation fidelity of Multi-systemic Therapy, and Functional Family Therapy funded by other agency partners in selected locations in Maryland. The Institute is also involved in a program to develop increased evidence of the effectiveness of the state's respite care and child and adolescent psychiatric rehabilitation programs.

In addition, MHA is funding a number of known evidence-based practices in the area of youth suicide prevention with support from a statewide Garret Lee Smith Suicide Prevention grant from SAMHSA. Local grants have been awarded to entities such as the CSAs and local school systems based on a competitive review of proposals that emphasize the implementation of suicide prevention evidence-based practices.

COMBINED ADULT AND CHILD TRAINING ACTIVITIES

First Responders

MHA, in collaboration with law enforcement agencies, offers training for officers, other public safety officials and community providers regarding the management of crises involving persons who appear to have a mental disorder and who may or may not have committed an offense. Training is provided through the MHA Office of Forensic Services, as well as by the local crisis response systems. Presentations include use of emergency petitions, approaching persons with mental disorders, the field interview of the person with a mental disorder, dealing with the suicidal individual, coverage of post traumatic stress disorder (PTSD) and treatment resources for active duty personnel and veterans. These presentations concentrate on the practical decisions that police officers have to make in the field, and are in plain, non-technical language. MHA will continue to participate in meetings with stakeholders regarding availability of mental health services for individuals with criminal justice involvement and on current or new programs and services provided by MHA's Office of Forensic Services such as diversion, services for inmates with mental illness, and discharge planning for pre/post release inmates. The Office will continue to provide training to MHA facilities and community forensic evaluators on the new reporting requirements for individuals committed as Incompetent to Stand Trial.

In collaboration with DHR, MHA through the CSAs have participated in the implementation of the Mental Health Mobile Crisis and Stabilization Service Initiative. This initiative provides community-based, 24-hour intensive in-home services to respond to crisis issues in foster/kin homes where DSS has placed children or for children who continue to reside with their families as a result of family team meeting intervention. This service is slated for a two-year implementation and is currently in place in 16 jurisdictions. Each jurisdiction has a team consisting of trained mental health professionals. The service is available 24/7 and in most jurisdictions relies on a warm-line for triage assistance. In most jurisdictions this service is supported through briefings to law enforcement and dispatcher training. DSS staff also provide training about foster/kinship care to mobile crisis providers, often in conjunction with foster care/kinship provider trainings.

Implementation of the Mental Health First Aid (MHFA) Program

MHA, in collaboration with the Mental Health Association of Maryland and On Our Own of Maryland, has started to educate the general public to recognize signs of an emerging mental illness or a mental health crisis through the Mental Health First Aid® (MHFA) program. More than 1,800 Marylanders have been trained during 75 sessions held by a corps of more than 60 certified instructors. The program is offered across Maryland in a variety of settings, including schools and universities. The Australian-based program was adapted for use in the United States through a collaborative effort among MHA, the Missouri Department of Mental Health and the National Council for Behavioral Healthcare. The MHFA Manual and Instructor Teaching Notes were

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published in October 2009 and are available in print through funding provided by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Maryland Transformation Grant.

Under DHMH Secretary's direction, Maryland became one of three national partners in bringing Mental Health First Aid to the USA and is currently a national leader, along with Missouri Transformation and the National Council for Community Behavioral Health, in sustaining this effort. MHA through the Mental Health Transformation –State Incentive Grant (MHT-SIG) is developing the capacity to respond to individuals experiencing psychiatric emergencies. Significant progress has been made over the past year in implementing the Mental Health First Aid (MHFA) initiative in Maryland and bringing the training certification program to individuals, organizations and communities throughout the State of Maryland. The corps of certified Instructors who are regionally distributed throughout the State has expanded to 42 individuals. Since the program's launch, 41 trainings have been held and over 800 Marylanders have been trained. Maryland's effort is led by four regional coordinators who are housed with local Mental Health Associations. These coordinators carry out marketing and community outreach functions and provide oversight and technical assistance to the 42 certified Instructors. On Our Own of Maryland, Inc. contracted with seven nationally known consumer leaders, from seven different states, to provide feedback and input on the MHFA manual. The MHFA Manual and Instructor Teaching Notes were scheduled to be released in late FY 2009. More than 2,500 draft manuals and 300 Instructor Training Kits have been produced and distributed for trainings conducted in Maryland and throughout the United States.

State Disaster Planning and Training Activities

The Director of Behavioral Health Disaster Services provides facilitation, support and technical assistance to enhance Maryland's ability to respond to the behavioral health needs that arise in the event of natural or man-made crises/disasters as well as enhance MHA, ADAA, DDA and Core Service Agencies (CSA) planning and preparedness. The Director reviews, facilitates updates and revisions to the All-Hazards Mental Health Disaster Plans for ADAA and MHA and all Core Service Agencies and conducts on-site review visits to each of Maryland's 20 CSAs. Currently, all plans both at the state and county level, are up-to-date. New MHA and ADAA drills and exercises are being designed and scheduled and technical support to CSAs on plan drills and exercises is offered.

Behavioral Health Disaster Services (BHDS) provides training to the Maryland Professional Volunteer Corps (MPVC) and assists the MPVC in their recruitment of additional disaster behavioral health volunteers. Two trainings were conducted in 2009 for MPVC volunteers. In addition, BHDS has developed and conducted disaster behavioral health trainings to numerous CSAs that wish to augment existing local disaster behavioral health volunteer teams as well as to other state agencies. Recently three full-day trainings were provided for the Department of Human Resources and a presentation was given to the Baltimore County Disaster Preparedness Conference. The Director has

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coordinated NIMS training for MPVC and for MHA and provides technical assistance in the maintenance of the MHA Incident Command System.

Behavioral Health Disaster Services (BHDS) also serves at the State Emergency Operations Center (SEOC) during any event which causes the SEOC to be activated; collaborates with Maryland Emergency Management Administration (MEMA), DHR and DHMH to provide behavioral health technical support and training running up to and during the Presidential Inauguration, the winter snow emergencies and developed situational specific handouts for both the public and the professional response community. BHDS also was active during the H1N1 outbreak both at MEMA and with DHMH providing technical assistance and message support.

In response to a request from the Office of Consumer Affairs, BHDS developed and implemented four train-the-trainers program for lead staff at Maryland's On Our Own Wellness and Recovery Centers incorporating disaster behavioral health and basic disaster preparedness concepts into the WRAP approach to health and well being for persons with mental health challenges. Participants included mental health consumers, Board members, interested general public participants and representatives from NAMI.

Seclusion and Restraint

Following MHA's receipt of a SAMHSA grant in FY 2005 to reduce the use of seclusion and restraint in the child-serving mental health facilities, a project director was hired at the EBPC. The project director's role is to provide education and consultation regarding techniques and strategies to achieve the reduction of seclusions and restraints to the state mental health inpatient and residential treatment facilities. Since July 1, 2008, following the ending of federal grant support, which focused on child serving facilities, the Transformation State Incentive Grant (MHT-SIG) has funded the Seclusion & Restraint elimination effort,. Springfield Hospital Center was selected as the first adult facility to receive S&R reduction activities under the supervision of the S&R project director.

Activities of the project director involve ongoing consultation at Springfield Hospital Center including grand rounds, weekly presentations on units, attendance at meetings, reviewing data and current trends on seclusion and restraint, and working with the Substance Abuse Specialist to assist in re-establishing a trauma informed care group for consumers. Activities at Spring Grove Hospital include consultation, meetings and the creation of a workshop on Wellness Recovery Action Plans (WRAP) conducted by consumers.

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Family Leadership Training

In addition to the Family Leadership Institute described in a previous criterion, the Maryland Coalition of Families provides two specific training curricula to families, Navigating the Juvenile Justice System and Navigating the Transition Years. Both of these training courses are reimbursable under the Medicaid waiver for family members of waiver service recipients, but these trainings are also considered essential for family members working as Family Navigators and as Family Peer to Peer Specialists under the waiver.

MHA also supports training through its CSAs. Local/regional trainings are provided dependent on local needs. Consumer, family, and advocacy groups receive funding to provide community education and training which target adult consumers, minorities, family members, children's mental health, and stigma issues.

The following list includes training and technical assistance activities that have been approved by MHA, which will be coordinated through the University of Maryland Training Center in FY 2010. Training events include projects for children and adolescents, adults and elderly consumers, as well as a multitude of special populations.
[NFC 1] [NFC 5]

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DESCRIPTION OF MHA FY 2011 TRAINING

1. Annual MHA Conference: This event will bring together stakeholders from the Public Mental Health System (PMHS) to address issues related to the new Health Care Reform and how that will affect mental health services in Maryland.
2. CSA Training/Technical Assistance: Provides for training related to system management including topics such as planning, service development, consumer relations, Evidence Based Practices, etc.
3. Interpreters: Funding for interpreter services at training events, to ensure ADA compliance.
4. Adult Services:
 - a. Person Centered Planning - Two series of two day Train-the-Trainer sessions followed by monthly webinars or conference calls for nine master trainers and four consumers on Person Centered Planning. The Evidence Based Practice sites will be the first to receive this training via Supervisors' Collaboratives set up for Supported Employment and Assertive Community Treatment supervisors, and incorporated into the training/consultation on Co-Occurring Disorders.
 - b. Regional Culture of Aging Training – Half day training targeting older adults with mental illness currently receiving services in the community. The goal is to provide additional tools beyond therapy and medication to enhance opportunities to sustain community living.
 - c. Annual Fire and Safety Training – Annual training on updated fire and environmental codes at the state and local levels.
 - d. TBI Waiver Provider Training – Targeted for Traumatic Brain Injury (TBI) waiver providers on neurobehavioral programming for the brain injury population.
 - e. Benefits Counseling and Work Incentives Training - Two one-day trainings to assist provider staff, advocates and consumers and their families to understand work incentives to assist Social Security beneficiaries with disabilities to return to work and retain Medicaid coverage.
5. Child/Adolescent Services:
 - a. Annual Youth Suicide Prevention Conference – 2011 keynote speaker is Jodee Blance, speaking on bullying.
 - b. Early Child Mental Health Training – Collaborative effort with the University of Maryland to train early childhood staff on core competencies of working with young children with mental health needs and their families.
 - c. MHA Child and Adolescent Annual Conference – One day event that brings updates and best practices to a broad group of providers, families and agency staff.
6. Office of Consumer Affairs:
 - a. Leadership Empowerment Advocacy Project (LEAP) – Four sessions focused on consumer recovery, advocacy, resilience, evidence based practices and outcome driven services.
 - b. Wellness and Recovery Directors' Training – Goal is to increase positive communication and collaboration among Center directors and their Core Service Agency counterparts.
 - c. Maryland Consumer Volunteer Network – Webinars to empower Center volunteers and board members to expand concepts of resiliency and recovery.
 - d. Person Centered Planning – In collaboration with the Adult Services Division, four LEAP graduates will be included in the train-the-trainer sessions of Person Centered Planning so they can bring this initiative to consumers.
7. Forensic Conference - 14th Annual Symposium on Mental Health and the Law
8. Cultural Competence Conference – “Creating Culturally Competent Care – The Journey Continues”. This will be an experiential/participatory event offering one of the first opportunities for a presentation of the updated version of the Surgeon General’s 1999 report on “Mental Health: Culture, Race and Ethnicity.”
9. Special Populations – One day conference focusing on individuals who are homeless, trauma survivors, deaf and hard of hearing, etc to increase awareness of services and enhance understanding of special needs.
10. Facilities Psychologists’ Meeting – Annual event bringing together psychologists from state facilities to explore new options to improve practice.

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11. On Our Own of Maryland (OOOMD), Recovery Project – Training and technical assistance on employment, recovery and wellness. Includes provision of individualized benefits counseling, Discovering Your Recovery Muse workshops and Steps to Wellness workshops, with a new four-session version of Wellness. Staff continues to support the Recovery Centers of Excellence pilot project.
12. OOOMD Summer Conference – Annual statewide conference for consumers focusing on recovery, empowerment and wellness.

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SFY 2011 OBJECTIVES FOR CRITERION 5:

SERVICES FOR ADULTS AND CHILDREN AND ADOLESCENTS:

- Continue the annual statewide client perception of care surveys of adults and parents/caretakers of children and youth regarding their experiences with PMHS services.
MHA Monitor: Sharon Ohlhaber, MHA Office of Quality Management and Community Programs
- Review and approve CSA mental health plans, budget documents, annual reports, and letters of review from local mental health advisory committees (LMHACs) and CSA advisory boards.
MHA Monitor: Cynthia Petion, MHA Office of Planning, Evaluation, and Training
- Monitor and collect documentation on each CSA's performance of activities, as outlined in the Memorandum of Understanding (MOU), on risk-based assessment of the CSA and specific MOU elements; and notify the appropriate MHA program director of exceptions that may require corrective action or additional technical assistance.
MHA Monitor: Alice Hegner, MHA Office of CSA Liaison
- MHA will develop cultural competence training curricula for selected provider agencies within the PMHS.
MHA Monitor: Iris Reeves, MHA Office of Planning, Evaluation, and Training
- MHA, in collaboration with the DHMH Office of the Deputy Secretary of Behavioral Health and Disabilities and other stakeholders, will participate in the development and implementation of Maryland's Action Plan to Eliminate Disparities in Behavioral Health Care.
MHA Monitor: Iris Reeves, MHA Office of Planning, Evaluation, and Training
- Based on a requirement for DHMH as a federal grant-receiving agency and on instructions from the Governor's Chief of Staff, MHA will have an all-hazards approach to emergency preparedness and response for MHA as an administration (including facilities) and for the mental health community at large.
MHA Monitor: Arlene Stephenson, MHA Office of the Deputy Director of Facilities Management and Administrative Operations
- Expand skills-based training opportunities to include Motivational Interviewing and Person Centered Planning to increase the effectiveness of service delivery within the PMHS.
MHA Monitor: Carole Frank, MHA Office of Planning, Evaluation, and Training

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- Continue to provide training, technical assistance, and consultation to promote Dual Diagnosis Capability (DDC) in mental health treatment.
MHA Monitor: Carole Frank, MHA Office of Planning, Evaluation, and Training
- Review MHA's budget and PMHS expenditures and services; implement corrective actions, as needed, to maintain operations within allocation.
MHA Monitor: Brian Hepburn, MHA Office of the Executive Director and Randolph Price, MHA Office of Administration and Finance
- Improve communication, and efforts that support activities that lead to implementation of health reform and coordination of care, in the delivery of services to individuals with mental illnesses.
MHA Monitor: Brian Hepburn, MHA Office of the Executive Director and Gayle Jordan-Randolph, MHA Office of the Clinical Director
- Monitor the delivery of forensic services and generate statistical information to inform policy and promote public awareness; analyze the impact of community-based forensic evaluations on hospital admission rates and lengths of stay for court-ordered individuals.
MHA Monitor: Larry Fitch, MHA Office of Forensic Services
- Continue to monitor the implementation of the Outcomes Measurement System (OMS), including completion of the transition of multiple, complex aspects of this initiative to the new ASO.
MHA Monitor: Sharon Ohlhaver, MHA Office of Quality Management and Community Programs
- Continue the annual statewide client perception of care surveys of adults and parents/caretakers of children and youth regarding their experiences with PMHS services.
MHA Monitor: Sharon Ohlhaver, MHA Office of Quality Management and Community Programs
- Enhance capacity for stakeholders to utilize PMHS data to measure service effectiveness and outcomes.
MHA Monitor: Susan Bradley, MHA Office of Management Information Systems and Data Analysis
- Participate in oversight of the Consumer Quality Team (CQT) project and plan for statewide expansion.
MHA Monitor: Clarissa Netter, MHA Office of Consumer Affairs
- The Child and Adolescent Mental Health Workforce Committee, chaired by MHA and MSDE, will develop a mental health training model for educators and continue development and delivery of curricula for training of staff in child mental health professions based on established core competencies.

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MHA Monitor: Al Zachik, MHA Office of Child and Adolescent Services

- Continue to enhance workforce development through the incorporation of peers into the workforce through the involvement of the following: Peer Employment Resource Specialist (PERS) Training, Maryland Association of Peer Support Specialists (MAPSS), Maryland Consumer Leadership Coalition, and Maryland Consumer Volunteer Network.

MHA Monitor: Clarissa Netter, MHA Office of Consumer Affairs

SERVICES FOR ADULTS

- Continue, in collaboration with the University of Maryland, CSAs, and key stakeholders, statewide implementation of evidence-based practice (EBP) models in supported employment, assertive community treatment, and family psycho-education.

MHA Monitor: James Chambers and Steve Reeder, MHA Office of Adult Services

- MHA, in collaboration with CSAs, will provide training for law enforcement officers, first responders, corrections personnel and other public safety officials regarding the management of crises involving individuals who appear to have a mental disorder and are charged with offenses or suspected of criminal involvement or juvenile delinquency.

MHA Monitor: Larry Fitch, MHA Office of Forensic Services

- Establish uniform standards, practices and outcomes for the Maryland Community Criminal Justice Treatment Program (MCCJTP) and the Trauma, Addiction, Mental Health, and Recovery (TAMAR) Project and monitor the delivery of mental health and trauma-based services to individuals incarcerated in local detention centers and in the community who have a mental illness and/or substance addiction.

MHA Monitor: Darren McGregor, MHA Office of Special Needs Populations

SERVICES FOR CHILDREN AND ADOLESCENTS

- In collaboration with the University of Maryland, the Johns Hopkins University, and the Maryland Coalition of Families for Children's Mental Health, continue the efforts of the Maryland Child and Adolescent Mental Health Institute to explore and implement child and adolescent evidence-based practices (EBPs) and other promising practice-based models.

MHA Monitor: Al Zachik, MHA Office of Child and Adolescent Services

- In collaboration with the University of Maryland's Research, Education and Clinical Center and the Maryland Child and Adolescent Mental Health Institute, implement best practices in psychiatry to address reduction of negative side effects of medication, prevention of obesity, and reduction in morbidity and

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mortality rates for adolescents and children with serious mental illness or serious emotional disorder with focus on psychopharmacological practices for youth in both foster care and juvenile justice settings.

MHA Monitor: Al Zachik, MHA Office of Child and Adolescent Services

- MHA will work in conjunction with Department of Human Resources (DHR), Care Management Entities (CMEs), and other stakeholders to improve screening, assessment, and service delivery for children and youth in foster care.

MHA Monitor: Al Zachik and Cyntrice Bellamy, MHA Office of Child and Adolescent Services

- In collaboration with Center for Medicare/Medicaid Services (CMS) and Maryland Medical Assistance (MA), continue implementation of the CMS-supported 1915(c) Psychiatric Residential Treatment Facility (PRTF) demonstration waiver to provide services for at least 80 children and youth and their families in four jurisdictions across the state.

MHA Monitor: Al Zachik, MHA Office of Child and Adolescent Service

- The Child and Adolescent Mental Health Workforce Committee, chaired by MHA and MSDE, will develop a mental health training model for educators and continue development and delivery of curricula for training of staff in child mental health professions based on established core competencies.

MHA Monitor: Al Zachik, MHA Office of Child and Adolescent Services

SECTION III

PERFORMANCE GOALS AND ACTION PLAN

TO IMPROVE THE SERVICE SYSTEM

Children's Mental Health Plan

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CHILDRENS PLAN

CRITERION #1: Comprehensive Community–Based Mental Health Service System for Children and Adolescents

Mental health transformation efforts and activities in the state are described within the narrative for each criterion and then referenced to the specific goal(s) in the New Freedom Commission (NFC) Reports.

AVAILABLE SYSTEMS OF TREATMENT, REHABILITATION, AND SUPPORT SERVICES

Services Available

Community-based mental health services and supports that are included in the fee-for-service benefit package for children, youth and families include:

- Psychiatric hospitals
- Psychiatric units of acute care general hospitals
- Residential treatment centers (RTCs)
- Psychiatric day treatment (also called partial hospitalization)
- Outpatient mental health clinics (many of which provide school-based and after-school treatment programs)
- Psychiatric rehabilitation programs
- Mobile treatment services (MTS)
- Supported employment (SE) and vocational services (for transition-age youth [TAY] age 16 and above)
- Residential crisis services
- Therapeutic behavioral aides
- Mental health related laboratory services

In addition to the broad range of services provided in the fee-for-service PMHS, youth admitted to the psychiatric residential treatment facility (PRTF) waiver (further explained in the following section) will be eligible for additional waiver services in addition to the PMHS services these services include:

- High Fidelity Wraparound Care Management
- Family to Family Peer Support
- Youth to Youth Peer Support
- Family and Youth Training
- In Home Respite Care
- Out of Home Respite Care
- Crisis and Stabilization Services
- Expressive and Experiential Services (i.e. art, movement, and music therapies, and horticultural and equine assisted therapies)

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Additionally, MHA provides funds through contracts to programs that offer specialized services (e.g. mobile crisis, therapeutic nurseries, and therapeutic group homes) that do not fit the fee-for-service model. These programs are eligible to apply for funds for programs such as family support groups, protection and advocacy services, juvenile court evaluation programs, and early childhood mental health consultation. A wide array of other child mental health services are also provided by other agency partners. Targeted case management is currently contracted through the core service agencies (CSAs), with one or more case management programs that provide linkage services and resources that will assist the consumer in stabilizing into the community. However, in FY 2010, MHA worked with Medicaid to amend the Medicaid State Plan and regulations for case management. CMS approval has been granted and MHA, in collaboration with the CSAs and the ASO is implementing and monitoring the transition from contracted case management services to the fee-for-service system (FFS) for Medicaid recipients and uninsured individuals. [NFC 2]

With regard to the MHA-operated Public Mental Health System (PMHS), any mental health provider who meets appropriate licensing, certification, accreditation, or other applicable standards is eligible to become a provider in the fee-for-service system. Eligible providers include facilities, programs, and individual practitioners. Individual practitioners include physicians, psychologists, nurse psychotherapists, clinical social workers, occupational therapists, and certified professional counselors who are allowed to practice independently under their Practice Acts. This increase in the provider community offers consumers an expanded choice of providers, including both approved mental health programs and individual licensed mental health practitioners. PRTF waiver services add Family Support Organizations to the mix of providers. Expressive and experiential therapies are provided by individual providers only.

In addition to the above services, coordinated service provision of a number of other service types is available within the child and adolescent system of care. Many of these are described below:

Employment Services - These services are primarily intended for transition-age youth (TAY) and, while they are funded as highly specialized TAY programs, the services of supported employment are similar to those described in the adult plan.

Housing Services - There are two primary housing concerns for children and youth with mental health needs: 1) out-of-home placement, and 2) affordable, adequate and safe housing for the family as a support to keep the child or adolescent in their community. Most housing, or “out-of-home placements”, in the child and adolescent service system are provided by the child welfare and juvenile justice systems. An array of kinship care, foster care, treatment foster care, group homes, therapeutic group homes, childcare institutions and residential treatment centers are available. All residential service policy in Maryland is developed and promulgated in an interagency context by the Interagency Licensing Board, operated out of the Governor’s Office for Children (GOC). MHA is currently involved with this group in a quality improvement effort regarding Therapeutic Group Homes, the only residential service option in the continuum

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of residential services that is regulated by MHA. A series of regular site visits and technical assistance designed to advance the programs' recovery and resilience orientations were conducted and during the past year, a reportable incident monitoring system was established to maintain quality of programs.

Mental health services, including outpatient, psychiatric rehabilitation, respite, and therapeutic behavioral aides are used to meet the mental health needs of children and adolescents in out-of-home placements. The Medicaid Section 1915(c) RTC waiver, a part of a CMS funded demonstration program offers alternatives to placement in residential treatment centers. This new demonstration project is described in greater detail in Criterion 3.

MHA and DHR work together in a number of venues focused on housing. The National Institute for Mental Health (NIMH) funded "Science to Service" evidence-based practice initiative focused on the implementation of treatment foster care. This is a service that falls into the nexus of mental health treatment and social services (or juvenile services) housing placement for youth unable to remain with their families. In FY 2006 MHA, in conjunction with DHR, the University of Maryland – Baltimore, and treatment foster care providers across the state completed Maryland's NIMH Science to Service grant assessing the use of evidence-based treatment foster care (TFC) in the state. Based on this work, a TFC Roundtable was convened in June 2007 to discuss approaches to promote the development and utilization of innovative treatment foster care in Maryland. The work of the TFC roundtable focused on moving implementation of TFC in the direction of more evidence based models statewide, an ambitious project that is being undertaken with the Maryland Child and Adolescent Mental Health Institute at the University of Maryland.

MHA's activities in the broader housing arena may affect families as well. Housing that is affordable, accessible, and integrated into the community is a major factor in enhancing the well-being and stability of children and adolescents and their families. MHA actively collaborates with both the Maryland Department of Housing and Community Development (DHCD) and the federal Department of Housing and Urban Development (HUD) to promote access and receipt of affordable housing through specialized government-supported housing opportunities. DHCD is represented on the Joint Maryland Advisory Council on Mental Hygiene/PL 102-321 Planning Council.

MHA encourages the CSAs to work with local housing authorities and affordable housing developers to maintain awareness of opportunities in their regions. To access housing, many local mental health providers have helped consumers successfully pursue HUD Housing Choice Voucher Programs and rental assistance services. One major implication of the mental health recovery movement is that consumers, particularly mothers, have increased opportunities to regain custody of their children and to live together as families. Several CSAs have also supported their local housing authorities in their applications for HUD Housing Choice Voucher Program vouchers for persons with disabilities and their families. Additionally, MHA has encouraged and provided some financial incentives to establish non-profit housing development entities. Many of these

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entities, as well as mental health provider organizations, have developed affordable housing through community bond grants through Maryland's DHMH's Administration-Sponsored Community Bond. MHA has identified housing as its priority for receipt of these bond monies. Projects have included development of affordable housing units for transition-age youth. Several of this year's Community Bond Program awards addressed this priority.

In 1995, the U.S. Department of Housing and Urban Development (HUD) awarded MHA a five-year, \$5.5 million Shelter Plus Care grant to provide housing for individuals who are homeless with serious mental illness (SMI) (with or without accompanying substance abuse) and their dependents, who are being released from the detention center or are in the community on the intensive caseloads of parole and probation. Last year, the FY 2009 Shelter Plus Care Housing grant was renewed for \$3,862,442 due to increases in the Fair Market Rental Values determined by HUD. Additionally in 2009, MHA received \$592,916 through seven small grants targeted to specific jurisdictions. The jurisdictions awarded the five-year grants were Allegany, Anne Arundel, Baltimore, Cecil, Frederick, Harford, and Prince George's Counties. Effective July 1, 2010 (FY 2011), MHA was awarded funding in the total amount \$3,306,900 for 16 of the Shelter Plus Care renewal grants. Currently, MHA is serving a total of 653 persons, 147 single individuals with mental illnesses and 172 families with 281 children and 53 other family members through all of the Shelter Plus Care programs.

School Based Mental Health - MHA continues its extensive work with the Maryland State Department of Education (MSDE), both in regard to strengthening student support services for students in regular classrooms and in special education settings governed by the requirements of the Individuals with Disabilities Education Act (IDEA). MHA and MSDE collaborate to provide services to children and youth and to recruit qualified mental health providers for schools and the community. There has been a considerable increase in school-based mental health services over the past several years. For example, mental health services are available in over 120 public schools in Baltimore City and in six schools in Baltimore County. There are currently 61 school-based health centers across the state, each of which provides somatic services. Approximately half of the centers also provide mental health services.

The Blueprint School Mental Health Committee (further explained in the following section) completed a statewide assessment of expanded school mental health availability in Maryland's 24 local jurisdictional school systems.

- **Positive Behavioral Interventions and Supports (PBIS)**-- Additionally, Maryland law requires elementary schools with suspension rates over 18% to implement the PBIS, or an alternative behavioral modification program, to reduce suspensions. Maryland State Department of Education (MSDE), in partnership with Sheppard Pratt Health System and Johns Hopkins University's Bloomberg School of Public Health, oversees and supports the statewide implementation of PBIS in Maryland. The partnership, known as PBIS Maryland, is responsible for providing training and technical assistance to local school systems. Each summer, the PBIS

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Maryland hosts a Training Institute for new teams and local school systems host a number of local/regional Training Institutes for their implementing schools. An increasing number of schools are choosing to use this program because of its success in improving school climate.

- MHA's Work Force project undertaken with the MSDE is described in greater detail in Criterion 5.
- Specialized efforts with the Early Childhood Educational sector and, for transition-age youth, with the Division of Rehabilitation Services (DORS), housed within MSDE, are described in subsequent sections.

Early Childhood Mental Health - The goal of the Maryland Early Childhood Mental Health Initiative is to increase the numbers of children who enter kindergarten ready to learn. Maryland has moved to a statewide assessment of children who enter kindergarten - the Work Sampling System - which provides a status report of children and their school readiness at the school and county levels. According to the criteria employed, Work Sampling System scores represent percentages of students who consistently demonstrate skills, behaviors, and abilities needed to meet kindergarten expectations successfully. The Work Sampling data are compiled in seven domains and also create a composite readiness score for each child. Over time these scores represent the level of progress the state has made in achieving its goal of increasing the number of children entering school ready to learn.

The strategy for early childhood mental health is to integrate mental health services into existing early childhood programs (children 0 to 5 years), to incorporate supports into existing early childhood programs, and to promote and support the integration of early childhood mental health services within other settings. The mental health component of the Maryland Infant and Toddler Program, which provides services for young children governed by Individuals with Disabilities Education Act (IDEA), is strengthened by the activities of the Early Childhood Mental Health Initiative. Additionally, the Initiative supports the provision of mental health services in day care services as well as federally-funded Head Start programs.

The Maryland State Early Childhood Mental Health Steering Committee provides direction to the Initiative. The Steering Committee is composed of a wide variety of organizations including: MHA's Office of Child and Adolescent Services; Maryland Coalition of Families for Children's Mental Health; MSDE; Governor's Office for Children; Department of Juvenile Services (DJS); Maryland Insurance Administration; Mental Health Association of Maryland; CSAs; Local Management Boards; University of Maryland Training Center; and other child serving agencies.

Findings from the recent evaluation of the pilot of early childhood mental health consultation with childcare providers indicated that that on-site consultation to child care programs delivered by interventionists who were knowledgeable about child development, individualized consultation for children at risk of being expelled from their child care programs, and consultation to providers about classroom-wide behavior management strategies had a number of positive effects. These effects included

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substantial decrease in expulsion for at-risk children, strong gains in social skills, reductions in children's problem behaviors, changes in teachers' behaviors, and improvement in the classroom environment. Based on the evaluation results of the pilot project; support from agencies, providers and families; and the success of the FY 2007 expansion of early childhood mental health consultation MSDE received \$2.5 million for FY 2008 to further early childhood mental health screening, prevention and intervention for preschool children at risk of developing emotional and mental health disorders. This funding ensured that consultation was available in all jurisdictions.

Services for Transition-Age Youth - MHA was awarded the Healthy Transitions Initiative (HTI) SAMHSA grant to support a transition service demonstration. This exciting new project is being implemented in Washington and Frederick Counties. It employs the Transition to Independence Process (TIP) model with a combination of a team of transition facilitators and expanded access for youth to both evidence-based Supported Employment and ACT, if needed. Interestingly, Washington County (Hagerstown and surrounding areas) is also the site of a U.S. Department of Education grant through Maryland DORS in which the public school system will focus on improving transition to adulthood for high school juniors and seniors with emotional disability. As far as we can determine, the Hagerstown area is the only location in the country where both the SAMHSA and US Department of Education grant programs are co-located.

In addition to this grant funded service demonstration, MHA funds services for youth moving from the child to the adult system in other counties. MHA fully implemented competitively awarded grant-funded transition-age youth (TAY) projects in ten jurisdictions (Baltimore, Worcester, Washington, and Garrett Counties; Charles County—in a tri-county project involving St. Mary's and Calvert Counties; Prince George's, Anne Arundel, Montgomery, and Howard Counties; and Baltimore City). No additional funding was appropriated for the last several years; however, MHA continues to support existing grantees through its system of core service agencies (CSAs). These projects are supported with state general funds provided through contracts to CSAs and with Medical Assistance (MA) through the fee-for-service system. These projects utilize different service approaches and target diverse and specialized populations (i.e. pregnant and parenting TAY with children; TAY transitioning from RTCs; supported education). MHA continues to review local CSA Plans for inclusion of services to TAY individuals and to identify diversionary strategies for supporting TAY in the community and preventing institutional placement.

MHA plans to utilize input from focus groups conducted by the Maryland Coalition of Families for Children's Mental Health to identify best practices in the delivery of services for transition-age youth (TAY) and begin dissemination activities. For example, a major thrust of the current plans to improve service to transition-aged youth evolved from themes identified in the Coalition's study. These included: 1) the transition age (roughly 16 to 24 years) is an especially difficult time for youth with mental health needs and their families who may continue many of the roles they had assumed when the child was younger due to lack of services; 2) structure is no longer

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provided by school and a number of decisions must be made about housing, employment or college requiring learning about a set of agencies new to the families and in which youth did not wish to participate due to perceived stigma; 3) youth expressed a strong desire for independence and yet lacked the experience, skills or emotional stability to work, manage their own finances, and have a productive life; 4) youth had career aspirations but felt that work was a major issue; 5) there was a gap between the youth's cognitive development and social and emotional development which impeded their ability to meet their goals for independence; and, 6) families were frustrated that when their children turned 18, parents were legally no longer able to be involved in their child's treatment although they were always the ones called upon in time of crisis.

Employment services are considered a priority for the "school to work" transition efforts listed on students' Individual Treatment Plans (ITPs) required by IDEA. The desire for a job may be a motivating force for older teens and young adults to keep them involved in their overall plan of care and movement toward self-determination. Outpatient and psychiatric rehabilitation mental health service providers, including school-based mental health services, can support the activities of the schools in transitioning students with mental health needs into the world of further training, education, or work. Many of MHA's TAY initiative projects focus on assisting youth to obtain and maintain employment. Supported employment services, as described under Criterion #1 of the adult plan, are available for older adolescents as well. MHA and the Department of Rehabilitation Services (DORS) collaborate on employment activities for adults with mental illnesses and their efforts to increase vocational counselors' understanding of the needs of individuals with psychiatric disabilities. This effort has fostered an increased understanding of the needs of youth with psychiatric disorders as well.

MHA also collaborates with other agencies to address services to the TAY target group. MHA participates through the Governor's Interagency Transition Council (ITC) for Youth with Disabilities, in working with designated state agencies to coordinate cross-training and integration of initiatives that may impinge on systems reform for TAY-serving agencies. The goal is: 1) to align and coordinate existing TAY services across state agencies and to identify new services to develop, enhance, and sustain TAY outcomes; 2) to enhance coordination and collaboration among stakeholders with relevant services; and, 3) to develop new policies and legislation to better meet goals and objectives.

Medical and Dental Services. The main low-income populations covered under Medicaid for medical and dental services include children and their parents, pregnant women, older adults, and individuals with disabilities. Medicaid also covers Medicare cost-sharing for certain low-income Medicare enrollees.

Federal Medicaid requires coverage of the following services: inpatient and outpatient hospital; physician, nurse midwife and certified nurse practitioner; laboratory and x-ray; nursing home and home health care; rural health and federally qualified health centers; and early and periodic screening, diagnosis, and treatment (EPSDT) for children

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under age 21. EPSDT requires coverage of all medically necessary services, including dental services, for children under age 21. The dental benefits offered typically include cleanings, fillings, and extractions. Maryland Medicaid also covers “optional” services, such as drugs, therapies, medical day care, and personal care.

On July 1, 2008 Maryland’s Medical Assistance benefits expanded to include comprehensive health care coverage for many more parents and other family members caring for children. Eligibility depends on family size and income. The income limit is about \$21,000 annually for a family of three. Funding was increased for Medicaid dental services over the next three years. The state has also set aside additional funds in a grant program for Maryland’s 24 jurisdictions to help local governments and non-profits to create new or expanded sources of dental care services that will increase the number of Maryland residents with access to a comprehensive and continual source of dental care. Additionally, the DHMH’s office of Oral Health is charged with developing statewide oral health prevention and educational strategies to decrease oral disease, conducting oral health survey of the State’s school Children, and providing grant monies for the establishment of local oral health programs targeted to populations at risk for oral disease.

In Maryland, about 80% of Medicaid beneficiaries, including almost all children with mental health needs who do not reside in a Psychiatric Residential Treatment Facility (PRTF), are in HealthChoice, Maryland Medicaid’s mandatory managed care program. Families choose, or are assigned, a primary care provider (PCP) and enroll in one of seven HealthChoice managed care organizations (MCOs). Special provisions are provided for children who are in the care and custody of the state with regard to how they are enrolled and services are provided. MCOs provide almost all Medicaid benefits, except for certain “carved-out” services that are provided on a fee-for-service basis. Specialty mental health is a key carve-out service. HealthChoice regulations require that MCOs provide medically necessary and appropriate dental services to enrollees who are younger than 21 years old. As noted in DHMH’s Maryland Medicaid eHealth statistic’s, 793,305 individuals were enrolled with Medical Assistance on May 2009. Of that number, 102,595 children were enrolled in Maryland’s Children’s Health Program (MCHP). Their benefit package and care is provided through MCOs as well.

In FY 2008, 24,798 children under age 13 and a total of 41,547 children and adolescents from age 0-18 were served through the mental health fee-for-service system. The needs of the child and adolescent population with co-occurring mental illness and substance abuse are a special concern for the system. Special efforts to coordinate care when these young people are encountered by the system are made by MHA, Alcohol and Drug Abuse Administration (ADAA), Developmental Disabilities Administration (DDA), and the special needs coordinators of the various MCOs. In particular, the juvenile justice population has a high rate of co-occurring disorders and efforts to integrate mental health treatment within the juvenile justice system places a high premium on the integration of mental health and substance abuse treatment approaches.

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DHMH promotes coordination of MCO and fee-for-service specialty mental health services. Enrollees can self-refer to the Specialty Mental Health System, and Medicaid regulations state that an MCO or an MCO PCP shall refer an enrollee to the Specialty Mental Health System when the MCO PCP cannot meet the enrollee's needs. The regulations also state that a MCO shall cooperate with the Specialty Mental Health System in developing referral procedures and protocols. The requirement that MCOs provide primary mental health care provides a clear linkage between a child's pediatric medical care and mental health treatment plan. The mental health benefits provided under the Early and Periodic Screening Diagnostic and Treatment (EPSDT) program are managed by the PMHS. Carving out this mental health benefit has facilitated identification and access to care for children and youth, particularly young children in the early stages of a problem.

Meetings among Medicaid and MHA staff, MCO medical directors, and the ASO's medical directors promote coordination. Special needs coordinators at the MCOS currently have access to identified care managers at the ASO, who are specifically commissioned to fulfill this coordinating function. In addition, information on pharmacy utilization is shared across systems. Medicaid receives real-time information on MCO and fee-for-service pharmacy claims in order to prevent drug contraindications at the point of sale. On a monthly basis, Medicaid sends reports to each MCO of their enrollees' fee-for-service mental health drug use, so MCOs and PCPs have information on the mental health drugs their enrollees are taking.

Pharmacy Services. In ongoing efforts to manage pharmacy costs, Medical Assistance (MA) developed a Preferred Drug List (PDL) to make better use of less expensive, but equally effective medications. Cooperating drug manufacturers have offered the state additional revenue in the form of supplemental rebates for purchasing some of the brand name drugs. Fifty-three classes of drugs currently fall under the preferred drug list. According to PDL regulations, for each therapeutic class where there are three or fewer drugs, the PDL may be limited to only one drug; for each therapeutic class in which there are four or more drugs, at least two drugs must be included on the PDL. Prescribing of non-preferred drugs requires a preauthorization. The PDL affects all fee-for-service recipients and those HealthChoice and Primary Adult Care (PAC) recipients who take certain mental health drugs. Preauthorization phone numbers and fax are available for prescribers who prefer to use non-PDL drugs. Preauthorizations for non-preferred drugs are granted upon request and require no justification or criteria at this time. There is also a hotline for recipients to use if they feel they are having difficulty getting their medications.

A new initiative planned for the upcoming year is to study the use of psychopharmacological drugs in the foster care population in order to determine current practice and assure appropriate prescribing patterns. Because this population is disproportionately more likely to be served in the mental health system and is known to experience higher levels of residential instability than the general population, continuity of care and follow-up for children in foster care are key issues to be examined.

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The Maryland General Assembly established the Maryland Health Insurance Plan under the Health Insurance Safety Act of 2002. A Board of Directors governs the plan, which operates as an independent unit of Maryland Insurance Administration. Individuals who are not eligible for group health coverage, COBRA, government – sponsored health insurance programs, and some other special categories may be eligible. The MHIP includes in its benefits coverage for mental health services. MHIP also has a Prescription Drug program which provides coverage at different levels and includes a deductible.

Educational services (including those provided by local schools and the Individuals with Disabilities Education Act (IDEA) - MHA continues its extensive work with the Maryland State Department of Education (MSDE), both in regard to strengthening student support services for students in regular classrooms and in special education settings governed by the requirements of the Individuals with Disabilities Education Act (IDEA). MHA and MSDE collaborate to provide services to children and youth and to recruit qualified mental health providers for schools and the community. An extensive array of school-based mental health services are available for students enrolled in regular education and in special education. As noted earlier, there has been a considerable increase in school-based mental health services and school health centers over the past several years that address a narrow band of adolescent somatic and behavioral health.

A major new project was undertaken in 2009 in the arena of special education policy. This effort evolved from a partnership of the Maryland State Department of Education (MSDE), the Coalition of Families for Children's Mental Health, and the MHA which will focus on outcomes for students identified with emotional disturbance in Maryland's school systems. This process directly addresses the specific needs of the most highly involved youth identified under the entitlement provisions of the Individuals with Disabilities Education Act (IDEA). A highly successful series of forums was held in the spring of 2008, which highlighted some of the challenges faced by this group of students. MSDE tracks a number of key data elements on students identified under IDEA with emotional disturbance. These data elements include the drop out rates, suspension/expulsion rates, and preliminary data on high school academic performance in English and Algebra. These data reveal troubling trends for all the students, particularly the transition-age youth, with mental health needs. More than 49 percent of nearly 9,000 students identified with emotional disturbance dropped out of Maryland schools in 2006, capping a rising trend of more than six percent across the past four school years. Prior to dropping out of school, students with emotional disturbance experience a disproportionately greater number of suspensions and expulsions than do other students with disabilities. Although students with emotional disturbance comprise slightly over eight percent of all students in special education, they account for 52 percent of all suspension/expulsion related disciplinary actions for special education students. This factor is all the more staggering when one considers that so many drop out of school prematurely. Academic proficiency testing in Algebra and English II reveals students scoring in the low 30 percent proficiency range compared to all Maryland high school students, whose aggregate scores are twice as high, registering over 60 percent proficiency on these assessments. To compound an already troubling picture, it must be

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noted that African American students are disproportionately much more likely to be identified as emotionally disturbed in Maryland schools. African Americans constituted over 56% of all students identified with emotional disturbance in 2006 while representing only 33% of the school-aged population (MSDE PowerPoint- “Meeting the Needs of Students with Emotional Disturbance in Schools”--April 28th, 2008).

Case Management Services

During the past year, Maryland achieved full statewide implementation of interagency care management through a contracted process conducted by the Governor’s Office for Children on behalf of the Children’s Cabinet. This exciting new development is described in the narrative below.

In addition, changes to MHA’s targeted case management program have been described earlier. In FY 2010, MHA worked with Medicaid to amend the Medicaid State Plan and regulations for case management to bring case management back under the Medicaid benefit design. Information for authorizations will again be reported to the ASO and payment will be based on the level of care that the individual needs in the community. Several counties have also provided case management through the PATH program, Shelter Plus Care community outreach programs, or special jail-based programs.

Substance Abuse Services including co-occurring disorders - DHMH is the agency responsible for mental health, substance abuse, developmental disabilities, AIDS, maternal and child health, and all the programs offered through the State Medical Assistance Plan. There is an ongoing need for coordinating mechanisms within the Department itself in order for DHMH to fulfill its role as an interagency partner with the other Departments of the Children’s Cabinet. The coordination of services for substance abuse, as well as developmental disabilities, with services offered to children and youth for mental health problems, is a critical issue within the DHMH coordination process. These needs all fall under the category of youth with special health care needs, and the primary systemic coordinating effort is DHMH’s Special Needs Advisory Committee.

In the past, Maryland has emphasized cross training of staff and coordination of services as a means of providing access to services by individuals needing both mental health and substance abuse services. A number of existing mental health treatment and rehabilitation programs, as well as programs established through the DHMH Alcohol and Drug Abuse Administration (ADAA), have developed dual diagnosis capability and are able to offer substance abuse treatment services to individuals with mental illnesses. [

The Secretary of the Department of Health and Mental Hygiene (DHMH) has also demonstrated commitment to co-occurring disorders by appointing an administrative officer from his office to work with MHA and ADAA. As a result of coordination through this position, a state-level leadership team has been convened to provide leadership toward enhanced service coordination across systems. There is now a State Charter, reflecting the state’s ongoing development toward service integration across the

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systems. Additionally, within DHMH, legislation established the Office of the Deputy Secretary for Behavioral Health and Disabilities. This Office includes responsibilities for developing a system of services for individuals with co-occurring disorders, to address systems change and to identify and implement specified treatment and supports.

The majority of the women with co-occurring disorders in the justice system have children and a smaller population is pregnant while incarcerated. MHA was instrumental in developing and implementing the TAMAR's Children Program to address the needs of these women and their children.

In 2007, MHA collaboratively worked with the Department of Public Safety and Correctional Services, the Administrative Office of the Courts, the Alcohol and Drug Abuse Administration, the Family Health Administration, Baltimore Mental Health Systems, Inc. and the Archdiocese of Baltimore to create a new statewide diagnostic and transitional program for pregnant women who are at least 18 years of age who might otherwise be incarcerated. As a result of this collaborative partnership, a new program, the Chrysalis House Healthy Start Program, was created. This program, funded through state general funds, consists of a 16-bed diagnostic and transitional facility (in the former location of the Tamar's Children Program) and serves pregnant and post-partum women and their babies.

After the newborn's birth, the mother and baby remain in the residential facility and receive a comprehensive array of services. Services include: medical care through contract with a health care organization; mental health treatment which includes trauma and attachment-based treatment interventions; substance abuse treatment and co-occurring treatment services; legal services; parenting and childcare services which include involvement from the Healthy Start and Family Tree Programs; housing; after hours residential support; health education; and other support services. [NFC 2]

Pregnant women may be referred by the courts, the state, Defense Attorney, or DHMH. A comprehensive assessment is conducted by a licensed clinician and an individualized treatment plan is developed between each woman and the treatment team.

MHA continues to offer and/or provide consultation to state and local agencies serving pregnant and post-partum women and their children on mental health and trauma. MHA also continues to fund outreach, case management, and housing assistance to graduates of the Chrysalis House Healthy Start Program through funding provided to Prisoner's Aid Association.

Activities to Reduce Hospitalization

MHA has directed efforts toward reducing the numbers and length of inpatient admissions, both in hospitals and in residential treatment centers (RTCs) for children and adolescents.

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Hospitals: Under the Lisa L. et al Settlement Agreement, the state continues to address the requirements for the timeliness of discharges for youth who are clinically ready to leave the hospital setting including both state and private Institute for Mental Disease (IMD) settings. At the end of FY 2004 Crownsville Hospital Center was closed, although bed capacity was maintained within the system. The adolescent unit located at Crownsville was relocated to Spring Grove Hospital Center. Four million dollars from the closure of the hospital was reallocated for community-based services in the five counties largely affected by the closure. Closure this past year of the Upper Shore Hospital and Walter P. Carter Centers did not affect the child and adolescent system as they were adult facilities. The ongoing impetus of the Lisa L. et al Settlement Agreement continues the reduced utilization of inpatient services at MHA-operated hospital units for adolescents. The ADP this year for the adolescent unit at Spring Grove Hospital Center was 12. MHA has not operated beds for children under age 12 since FY 1994. Beds are purchased, from the private sector, when necessary.

Residential Treatment Centers: A major development in the recent past has been the closure of one of three state-operated Regional Institutes for Children and Adolescents (RICAs). As a result of the state's fiscal situation and the under utilization of the program in Cheltenham, Maryland, the Maryland General Assembly acted to close the program by June 30, 2008. During the past fiscal year, both of the remaining programs have reduced their capacities as a result of legislative action. The legislature ordered MHA to conduct a study of available beds in both public and private sectors with the intent of right sizing the system. General Assembly was advised that existing private programs were adequate to the need. During the past year, the CMS-funded Psychiatric Residential Treatment Facility Demonstration program has begun to serve increasing numbers of youth in the community as an alternative to RTC placement. This trend may continue over the next several years, depending upon available resources.

An issue of concern within the hospital system is the number of children and adolescents who are in acute inpatient beds, ready for discharge, without adequate insurance coverage and whose parents, without additional supports, are unable to care for them. In many instances, the child's insurance will cover acute inpatient care, but not the range of community-based services that the child requires to successfully return home or to an interim placement. Often, a recommendation is made for more restrictive RTC placement in order to access MA eligibility as a "family of one" the eligibility deeming rules which allow the state to disregard the family's assets and income in making the determination. The new section 1915(c) waiver is expected to provide families with access to more community services when this is the case and help to offset the problem of forced or voluntary custody relinquishment.

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DEVELOPMENT OF AN INTEGRATED COMMUNITY-BASED SYSTEM OF CARE FOR CHILDREN'S BEHAVIORAL HEALTH SERVICES

As described briefly in Section II, the Children's Cabinet is Maryland's state level interagency body charged with development and implementation of an integrated interagency system of care for children, youth and families. Maryland was among the first states in the nation to legislatively create an interagency coordination body with the passage of Chapter 426 of the Acts of 1978. Subsequently, the General Assembly formalized the creation of the Subcabinet for Children, Youth, and Families in 1990. The existence of such an enduring interagency structure creates a highly effective venue for interagency policy development and implementation. The Children's Cabinet is composed of the Secretaries of all the major executive departments that directly provide or finance service delivery to youth and their families. These agencies include: Maryland State Department of Education (MSDE), Department of Health and Mental Hygiene (DHMH), Department of Juvenile Services (DJS), Department of Human Resources (DHR), Department of Disabilities (MDOD), and Department of Budget Management (DBM). The Governor's Office for Children (GOC) provides staffing and coordination functions for the Children's Cabinet. The Children's Cabinet collaborates to promote the vision of the state for a stable, safe, and healthy environment for children and families. The Cabinet also assesses need, establishes budget priorities, and develops interagency initiatives to address these specific priority needs.

The Children's Cabinet set forth its first Interagency Strategic Plan in July 2008 to accomplish these ends. The plan is organized under a number of broad cross agency themes that include the following: {1} Family and Youth Partnerships; {2} Interagency Structures; {3} Workforce Development and Training; {4} Information Sharing; {5} Improving Access to Opportunities and Care; {6} Financing; and {7} Education. A number of recommendations and specific strategies are articulated across a multi-year span within this interagency planning framework. Correlations with the statutory requirements of the Block Grant are clear.

Prior to the articulation of the Interagency plan, work of the Children's Cabinet was based in the methodology of Results Accountability, a strategic planning approach that produced over a decade of trend data for an established set of results and indicators reflecting on the broad well-being of children and families in Maryland. The new State Interagency plan narrowed the focus of these results and indicators to four principal areas as priorities for Maryland, while maintaining a strong Results Accountability approach. The four areas are: {1} Rates of out-of-home placement for youth under 18; {2 & 3} Educational indicators for two different points along the developmental spectrum, including 3rd grade reading proficiency and educational attainment (i.e. diploma, GED, some college vocational training etc.) for young adults 18 to 24 years of age; and {4} Juvenile arrest rates (both violent and non-violent offenses) for youth 15-17. Data on these four indicators follows from the Interagency Plan:

Out-of-Home Placement

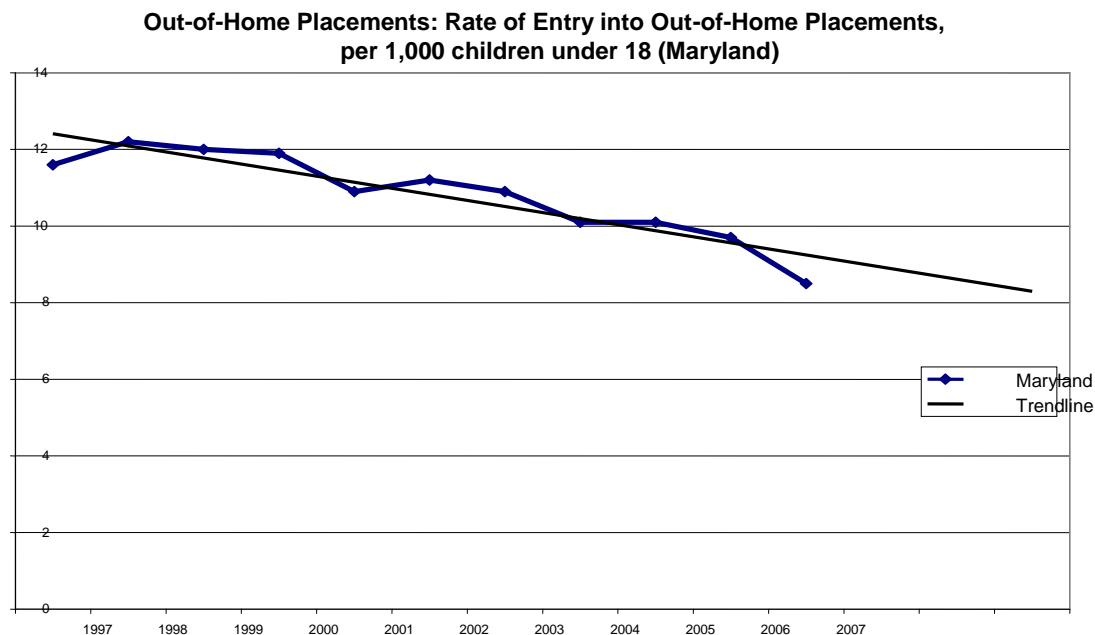
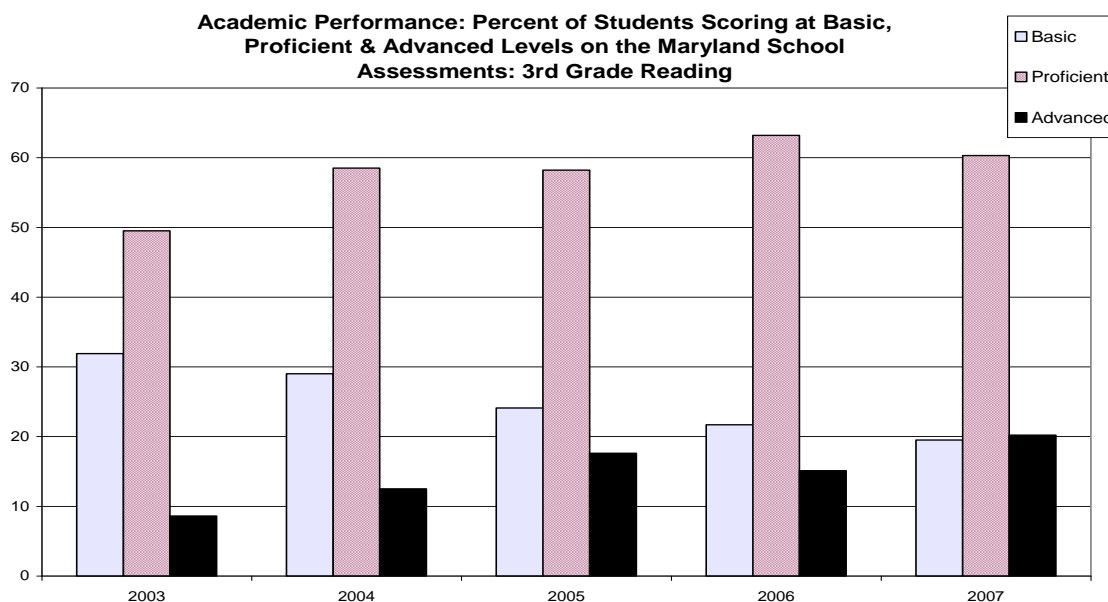


Figure 1: Rate of Entry into Out-of-Home Placements (Source: Governor’s Office for Children, 2008).

As can be seen from this graph, the rate of entry into all out-of-home placements in FY07 was the lowest in ten years, at 8.5 per 1,000 children under 18 years old. FY07 also marked the lowest number of entries into out-of-home placement in at least ten years, with 12,920 entries. Despite the downward trend in the rate of out-of-home placements, the cost for these placements continues to rise; the cost was \$765 million in FY07 compared to \$720 million in FY06. While the majority of out-of-home placements are from DHR (54%), this percentage has been declining over the past several years. DJS had the second largest percentage of children in out-of-home placements (37%), with DHMH and MSDE-funded placements representing the remainder (Governor’s Office for Children, 2008b).

3rd Grade Reading

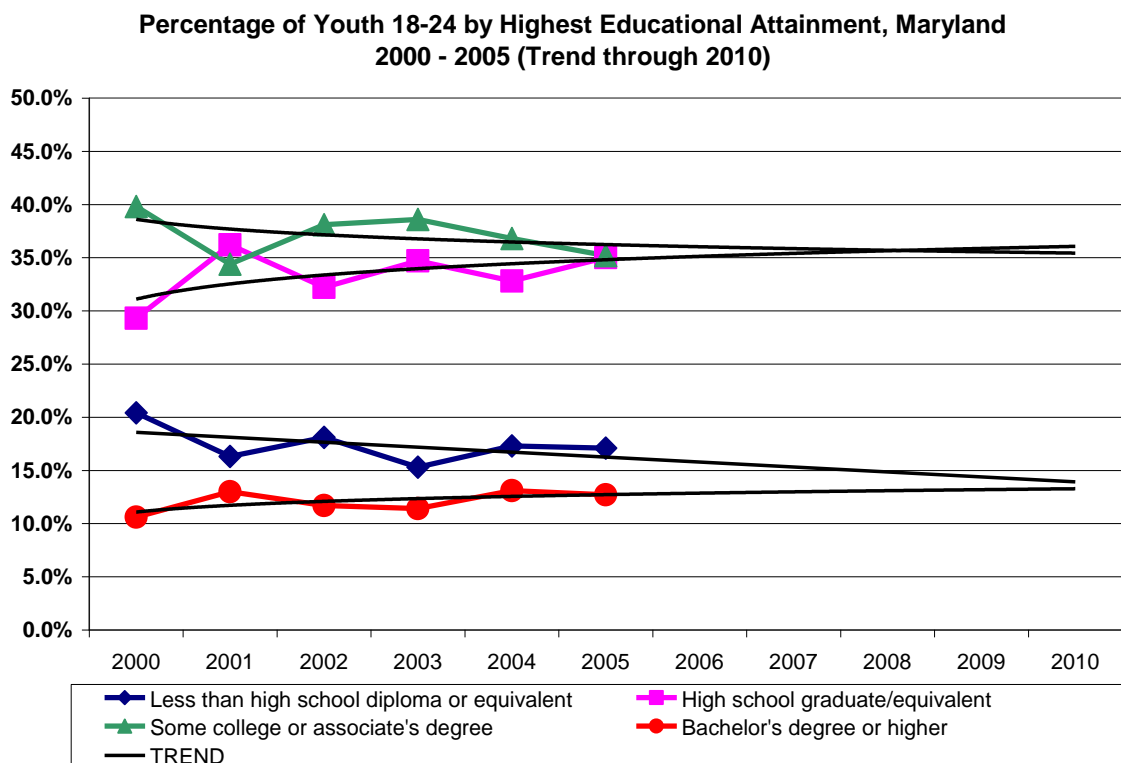


Source: Maryland State Department of Education, 2007.

Figure 2: 3rd Grade Reading

As Figure 2 illustrates, the percentage of third grade students in Maryland who are scoring at basic levels on the reading component of the Maryland State Assessment has been in steady decline over the past four years. The percentage of students who scored at the advanced level was the largest since 2003, which is indicative of the trend heading in the right direction. However, there is a need to accelerate this trend, as almost 20% of third grade students still do not score at least at the proficient level.

Educational Attainment



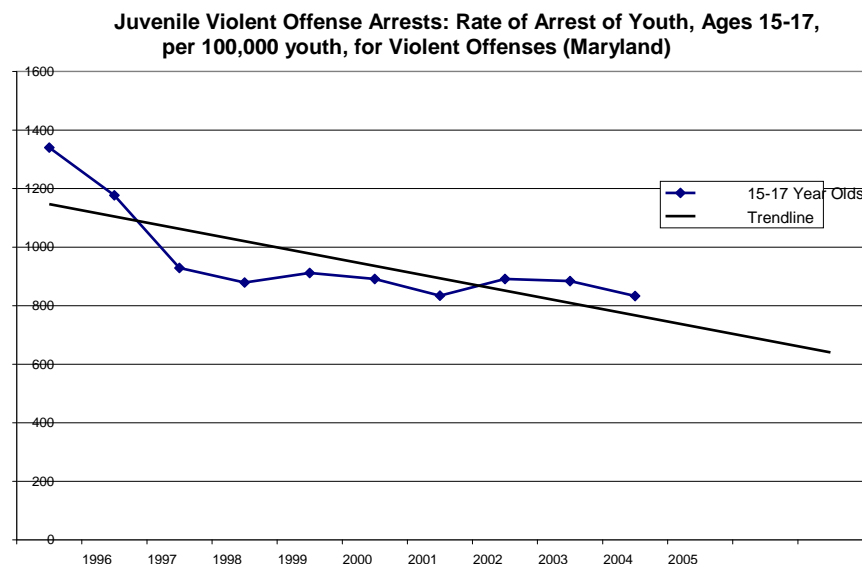
Source: Census 2000 Summary File 3, Table PCT25 (calculated); Supplementary Survey (U.S. Census) 2001, Table PCT033 (calculated); American Community Survey (ACS) 2002, 2003, Table PCT033 (calculated); ACS 2004, 2005, Table S1501

Figure 3: Educational Attainment

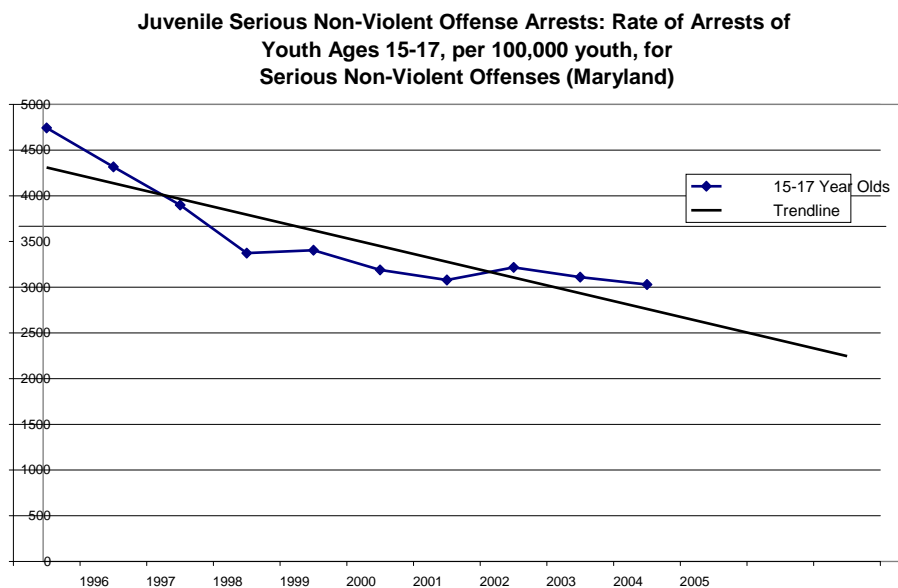
In 2005, 17% of Maryland youth ages 18-24 had less than a high school diploma or equivalent and 35% of youth had some college or an associate's degree. As the *Ready by 21: An Action Agenda for Maryland* report notes, this is "not good enough" (Governor's Office for Children, 2007c, p.10). Median earnings for males over 24 with at least a bachelor's degree are \$35,802 greater than males without at least a high school diploma. For females, the difference is \$25,715 between individuals with at least a bachelor's degree and those without a high school diploma. Even those individuals with a high school diploma have median earnings that are considerably less than their peers with a bachelor's degree (U.S. Census Bureau, 2007). Educational attainment is important not only because of its direct relation to economic independence but also because it serves as a proxy measure for access to opportunities, both during childhood and in the future.

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Juvenile Offense Arrest Rates



Source: Maryland State Police Uniform Crime Report, as published in Results for Child Well-Being (Governor's Office for Children, 2007a).



Source: Maryland State Police Uniform Crime Report, as published in Results for Child Well-Being (Governor's Office for Children, 2007a).

Figures 4&5 The data displayed in figures 4 and 5 are for the offense arrest rates for 15-17 year olds in Maryland for violent offenses (murder, forcible rape, robbery, and aggravated assault) and serious non-violent offenses (breaking and entering, larceny/theft, and motor vehicle theft). Both of these graphs show the trends moving in the right direction, with declines in the rate of arrests. The rate of violent offense arrests has declined by 37.8% since 1995, and the rate of serious non-violent offense arrests has declined by 26.1% during that same time. It is, however, a priority of the Children's

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Cabinet to accelerate these declines to both improve public safety and produce better outcomes for children and youth.

Role of MHA in the Interagency Strategic Plan - It is clear that mental health services and supports across the child and adolescent developmental spectrum are a vital component of addressing outcomes in all four of the major outcome areas targeted by the Children's Cabinet. Speaking more specifically, as noted in Section II, a major focus of activity for MHA under the Interagency Plan is taking the lead in implementation of the Centers for Medicare and Medicaid (CMS) funded Psychiatric Residential Treatment Facility (PRTF) Demonstration Waiver. This initiative, as described below, will contribute both to the reduction of out of home placements at PRTF level of care and also in maintaining family preservation whenever possible. The waiver will also improve coordination of care and advance educational attainments for older youth and help reduce arrests for adolescents when they enter the transitional years.

Center for Medicare/ Medicaid Services PRTF Waiver - Maryland has been granted a Section 1915(c) Medicaid waiver for home and community-based services for children and youth at the Psychiatric Residential Treatment Facility (PRTF) level of care. Maryland is one of ten states selected to participate in the Centers for Medicare and Medicaid (CMS) sponsored PRTF demonstration which is based on using section 1915(c) federal Medicaid demonstration waivers to divert youth from psychiatric residential treatment and provide them with community-based services. Known in Maryland as the RTC Waiver, this effort is based on two high Fidelity Wraparound pilots begun in January 2006. State funding was received through the GOC to expand the program in FY 2007 to an additional two jurisdictions that are able to provide high-fidelity services. At the time of this writing, approximately 80 youth have been enrolled and a total 210 slot have been reserved for youth who are at various stages of the application process. The target population for the waiver is children, youth, and their families who meet the medical necessity criteria for psychiatric residential treatment facility (PRTF) admission. Regulations have been developed to govern the waiver and its operations and provider recruitment has been conducted. Children may remain in the waiver for up to 24 months with annual review.

A major component of the implementation of the waiver includes the implementation of Interagency Care Management Entities (CMEs) statewide. Contracts to two private vendors have been awarded to deliver this service statewide. This effort is strongly integrative of the agency efforts in Maryland as it will provide care management in addition to the PRTF waiver, also for youth placed at the group home level by both DHR and DJS and two System of Care grants for youth in child welfare in Baltimore and the Eastern Shore of Maryland, Maryland CARES and Rural CARES.

Clearly, Maryland has a long track record in creating extensive interagency infrastructure and interagency mechanisms for sustaining and improving an integrated system of care for children, youth, and families under the broad aegis of the Children's Cabinet. Much of our success in interagency planning is based on the next element of the narrative, Maryland's commitment to youth and family involvement.

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Youth & Family Involvement - The value placed on youth and family member participation continues as a major priority of the Child and Adolescent Mental Health System. This value also appears as the first element of the Interagency Strategic Plan. MHA and its partners encourage the input of youth, family members, and adult consumers across the board. A concerted effort is made to include all in the planning, development, and monitoring of the PMHS. In FY 2010, MHA will continue to fund the Maryland Coalition of Families for Children's Mental Health, a statewide child and family advocacy group, to develop local family support activities. The Coalition has a mission to inform families of children and adolescents about policy, to teach them about becoming participants in the policy and decision-making process, and to provide feedback about the operations of the Public Mental Health System. The Coalition participates on more than 22 state and local policy shaping committees. At the current time, over 50 family members are employed by the Coalition, its local counterparts, or in local child serving systems as providers of peer-to-peer support and assistance to families in navigating the system.

A highly successful project of the Coalition of Families, jointly with the Maryland Mental Health Association, is the "Children's Mental Health Matters" public awareness campaign. This project is a significant social marketing effort designed to: improve public information, reduce the stigmatization of youth with mental health conditions, and garner public support for innovative system development through a major public awareness campaign. This effort may, in some ways, be one of the greatest strengths of this year's Mental Health Block Grant application because it goes beyond limited mandates for service improvement while addressing deeper contextual issues required for lasting system change and better results. The campaign is a partnership with local broadcast affiliates and involves Maryland's First Lady, Katie O'Malley, as Honorary Chair and Debbie Phelps, mother of Maryland's celebrated Olympic swimmer, Michael Phelps, as media spokeswoman. A major media blitz occurred during Children's Mental Health Week during the past May and will be continued in the upcoming year.

The Coalition has conducted extensive research over the years, including studies using focus group design, of parents involved with custody relinquishment, the juvenile justice system, transition-age youth (TAY) and families of young children engaged with the early childhood education system. These studies have been described in past years' plans and they provide an excellent and highly effective basis to support advocacy and policy initiatives designed to improve the child and adolescent system of care. In addition, in FY 2004, the Coalition established a Family Leadership Institute (FLI) which has continued producing new advocates every year since. FLI provides a six-month training program for families in navigating the child and adolescent mental health services system in Maryland and in becoming advocates in their communities and the state. Twenty families participated in the first Institute. The fifth Family Leadership Institute was held this year with 20 graduates, increasing the total number of trained family advocates to 115 over the five years of the Institute implementation.

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Youth MOVE - In June 2007, Maryland initiated its Youth MOVE (Youth Motivating Others through Voices of Experience) program which provides training for youth to be active participants and leaders in seeking services for themselves and for the community of youth. Maryland's effort is based on the national model. More information is available at (<http://www.tapartnership.org/youth/YouthMOVE.asp>).

Last year, MHT-SIG established Youth MOVE Maryland by hiring a statewide coordinator housed within the Innovations Institute (described in a following section). Youth MOVE has been funded in 13 of the state's 24 jurisdictions. The further statewide roll-out and continued efforts will be sustained through the new Systems of Care (SOC) grant award. Accomplishments include the following: creation of a Youth MOVE Myspace page and brochure; several meetings with senior state officials; and a number of county-specific social marketing activities.

The Child and Adolescent Division of MHA also works, when appropriate, with On Our Own of Maryland (OOOMD), the statewide mental health consumer network. Areas include efforts to fight stigma within the mental health system through the Anti-Stigma Project (ASP), which is described more fully in the adult plan. Exploration of utilization Of Wellness Recovery Action Planning (WRAP) for TAY and other transition-age youth issues.

Maryland's Blue Print Committee - A major outgrowth of Maryland's family involvement philosophy was the development of the Maryland Blue print for Children's Mental Health. This ongoing strategic planning effort was originally developed in 2003 at the request of our statewide family organization and the Blueprint was updated this year in the spring of 2009. It is a five-year strategic plan which extends the work of the 2003 Blueprint to address the mental health needs of children, youth and their families. The guiding philosophy of care found in the Public Health Model, with its emphasis on the health of an entire population beginning with health promotion, prevention and early intervention, is central to this 2009 update. The revised vision and mission, as well as the recommendations and suggested strategies themselves, are rooted in the broader public health approach to mental health.

Six major themes emerged which became the basis for recommendations and suggested strategies. Within each theme, the recommendations were prioritized. The six themes and the most highly prioritized recommendation in each are listed below.

- **Mental Health Promotion, Prevention and Early Intervention**
 - Increase and coordinate mental health promotion efforts, increasing protective factors and decreasing risk factors through individual and community education for all age groups across all jurisdictions
- **Family and Youth Partnership**
 - Ensure that Family and Youth are equal partners at every level of statewide and local decision making throughout each phase of policy, program, and evaluation in all jurisdictions

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- Infrastructure Development
 - Develop sustainability for core levels of services, supports, and opportunities in each jurisdiction (as proposed in Continuum of Services and Supports below)
- Workforce Development
 - Strengthen services by providing adequate pre-service and in-service training, resources, and leadership to all those who provide direct care to children, youth and their families across disciplines and populations
- Access to Care and Opportunities
 - Provide consistency in policy, practice, and funding across agencies and throughout local jurisdictions
- Continuum of Services and Supports
 - Define and develop an accessible baseline, or foundation of services and supports, in every jurisdiction in Maryland

The Maryland Child and Adolescent Mental Health Institute - A major outgrowth of the original Blue print Committee process was the development of the Maryland Child and Adolescent Mental Health Institute. The Institute is a joint project of Johns Hopkins and the University of Maryland (UM) Schools of Medicine. A number of key related projects run by the Institute include: {1} a SAMHSA-funded effort to reduce seclusion and restraint in state-operated child and adolescent mental health facilities; {2} a SAMHSA-funded Child Trauma Center; and {3} a project focused on implementation of Treatment Foster Care implementation, a process begun under the National Institute of Mental Health (NIMH)-SAMHSA Science to Service grant. In addition, a special focus has been placed in partnership with DHR and the UM School of Social Work on development of trauma-informed care and evidence based Cognitive Behavioral Therapy for children and youth in the foster care system. Funding from the MHT-SIG has been provided through the Institute to the UM Center for School Mental Health Assistance, one of only two national centers on school mental health funded by the federal government, to study the educational needs of children in child welfare.

- In addition to the above, the Maryland Child and Adolescent Innovations Institute, of the University of Maryland Division of Child and Adolescent Psychiatry, was initiated in 2005 to assist the State of Maryland, the Children's Cabinet, the Governor's Office for Children (GOC), Maryland jurisdictions, and the state's child-serving agencies to support efforts in improving access, services and outcomes for families of children with intensive needs. Innovations Institute seeks to assist the state of Maryland and local jurisdictions with obtaining skills, interpreting new knowledge, and adapting policy and practice to ensure that Maryland's children, youth, and families achieve wellness through family-driven, youth-guided, culturally and linguistically competent, and individualized quality care within a system of care. The Innovations Institute is funded by the Governor's Office for Children (GOC).

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- The Johns Hopkins University School of Medicine offers a broad range of research, educational, and clinical resources. The Department of Psychiatry and Behavioral Sciences has over 200 full-time faculty members and an extensive program of research supported by multiple funding sources, including over \$38 million annually in National Institutes of Health (NIH) grants. The Division of Child and Adolescent Psychiatry consists of 40 full-time faculty members who are located in diverse clinical settings. The faculty are committed to training clinical researchers in the following areas of interventions research with children and adolescents: 1) efficacy studies evaluating new or available but un-validated medication and/or psychosocial treatments; 2) effectiveness studies of empirically supported treatments applied in diverse populations and settings; 3) safety and adverse effects of psychotropic medications, particularly during long-term treatment; and 4) methodological approaches and techniques that inform the specificity of treatment to identify which treatments work best for which individuals. The research environment in the Division of Child and Adolescent Psychiatry is very collaborative in nature, offering many opportunities and resources.

Social Services - The social service sector in Maryland is primarily housed in the Department of Human Resources (DHR). For child and adolescent planning purposes, the majority of social services are administratively located in the Social Services Administration (SSA). The principal functions of SSA are child welfare focused including child protection, kinship care, formal custodial placement of children in a variety of out of home placements, family reunification, and adoption/post adoption services. It is important to note that the juvenile court in addition to the role it plays in the juvenile delinquency sector interfaces with the social service sector through its dependent youth docket. Both juvenile and social services will be discussed again in the subsequent section on housing. Collaboration with social service providers is particularly important given the high prevalence of mental health disorders among children who are in custody of the state's child welfare system. Local social service agencies in each jurisdiction are called Departments of Social Services (DSS). MHA tracks the percentage of selected categories of youth in the child welfare systems, who receive services via the PMHS, as a performance indicator.

- **“Place Matters”**--A current major priority of DHR is the “Place Matters” campaign. The agency joined with the Annie E. Casey Foundation's Casey Strategic Consulting Group to reform foster care in the state. DHR is spearheading a three-year effort to bolster 1,000 new foster family homes by 2010 so that children live in closer proximity to their family members and their communities. Specific recruitment goals for each region of the state are guiding the outreach. Key Performance Measures for Place Matters include: {1} reducing the number of children in out-of-home care; {2} reducing the number of children in group homes; {3} increasing the number of children placed in their home jurisdiction; {4} increasing the number of children who reunite with their family; and {5} increasing the number of adoptions.

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- **“Other DHR”** - Other DHR social services that are housed outside of child welfare, which also come into play in planning and delivery, include homeless services, domestic violence services, victim services, adult services, and Medicaid eligibility services, (notably for Medicaid waivers). It is important to note that child care services, typically considered a social service, are administratively housed in Maryland within the Department of Education. As a result, these services will be discussed subsequently in conjunction with early childhood education. For those youth and young adults in the transitional youth age range, the full array of adult oriented social services also become a part of the overall system of integrated services required.
- **“MD CARES” & Rural CARES** – Funded through Two SAMHSA system of care grants, MD CARES and Rural CARES are key child welfare collaborations in major geographic and population centers of the state. These projects will develop a cross-agency partnership that blends family-driven, evidence-based practices within mental health and child welfare to better serve this high risk population. In Maryland there are approximately 10,100 children in foster care, of which approximately 6,100 are from Baltimore City. Grant funds will be used to expand and support “wraparound” services to foster children in their communities. Wraparound services provide a comprehensive array of home and community-based services to maximize the strengths of families, natural support systems, and community resources. These services are different from traditional “one size fits all” programs and expensive residential care.
- **Crisis Stabilization and Response** – A related joint venture with DHR that first appeared in last year’s plan, is the creation of a mental health crisis response and stabilization system designed to facilitate response to children in foster care placements and intervene in the home setting so that psychiatric crises and resulting hospitalization do not result in the disruption of the child’s residential placement. This initiative was funded in the Governor’s budget and approved by the General Assembly to commence in FY 2009. Program start-up began in selected jurisdictions in September 2008. Nine service provision areas covering 16 counties have been initiated. These include the Lower Shore region; Mid-Shore region; Allegany, Garrett, Washington, Baltimore, and Anne Arundel Counties; and Baltimore City. During the upcoming year jurisdictions plan to hold extensive trainings of local first responders, police and Emergency Management System (EMS) staff, about the special needs of foster families. Harford, and Prince George’s Counties originally planned for statewide implementation. However, further expansion of this project has unfortunately been curtailed due to budget limitations.
- **School Mental Health Foster Care Project** – This special project has made a number of accomplishments. It is believed to be the first project in the United States to explicitly connect school mental health outreach and services for youth in foster care. The project has established a diverse and influential advisory board of 40 systems leaders and stakeholders from over 20 organizations. In addition, ten modules for training child welfare, education, and mental health systems staff, with strong youth and family involvement, were completed and a partnership with Maryland’s Child Welfare Academy was established with the first full-day

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training held in December 2008. A School Mental Health and Foster Care Issue Brief was disseminated broadly within Maryland. MHA and the Maryland Child and Adolescent Mental Health Institute are completing a special project on the use of psychopharmacological treatments with foster care children, described in subsequent section.

Juvenile Services – The Mental Hygiene Administration (MHA) consults and collaborates with the Department of Juvenile Services (DJS) to coordinate mental health services within their juvenile detention centers. The mental health programs focus on the needs of youth in the care of DJS prior to adjudication and disposition by the juvenile court.

The MHA Child and Adolescent staff provide training for DJS direct care staff on an as needed basis. In FY 2010, the MHA Director of Child and Adolescent Services began a Psychopharmacology Learning Collaborative consisting of psychiatrists who provide services to youth in the juvenile justice system. The focus of the Collaborative is to examine the use and administration of psychotropic medication to youth in custody.

Youth in the juvenile justice system will benefit from the implementation of Interagency Care Management Entities (CMEs) statewide. Contracts to two private vendors have been awarded to deliver services. This effort is strongly integrative of the agency efforts in Maryland as it will provide care management in addition to the PRTF waiver, for youth placed at the group home level by both DHR and DJS. The CME serves as the clinical home for high utilizing populations of children with serious mental health challenges. The focus is on strength-based service planning that is coordinated across agencies and providers, intensive care management, and home and community based alternatives to residential and hospital care.

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SFY 2011 OBJECTIVES FOR CRITERION 1:

SERVICES FOR CHILDREN AND ADOLESCENTS

- MHA, in collaboration with the Core Service Agencies (CSAs), will continue to provide support, funding, and ongoing consultation to Maryland's mental health advocacy groups to promote and implement a series of public education and training activities to increase awareness of mental illness; mental health issues; and recovery and resiliency among children, youth, and adults.
MHA Monitor: John Hammond, MHA Office of Public Relations; Al Zachik, MHA Office of Child and Adolescent Services; and Cynthia Petion, MHA Office of Planning, Evaluation, and Training
- Provide resources to continue to implement leadership activities and trainings through the Maryland Coalition of Families for Children's Mental Health Leadership Institute for parents of children with emotional disorders; the Youth MOVE (Motivating Others through Voices of Experience) peer leadership program; and the Leadership Empowerment and Advocacy Project (LEAP) for adult consumers.
MHA Monitor: Al Zachik, MHA Office of Child and Adolescent Services and Clarissa Netter, MHA Office of Consumer Affairs
- MHA, in collaboration with CSAs and other stakeholders, will continue efforts to address and implement suicide prevention activities for youth, adults, and older adults.
MHA Monitor: Henry Westray, MHA Office of Child and Adolescent Services
- Convene at least two educational seminars on work incentives to assist consumers with mental illnesses to return to work and retain access to needed benefits and health insurance.
MHA Monitor: Steve Reeder, MHA Office of Adult Services
- Based on a 1987 Lisa L. Program class action lawsuit (which requires timely discharge from hospitals to appropriate placements), track and monitor children and youth in state custody in designated psychiatric hospitals as identified under Code of Maryland law (COMAR) 14.31.03.
MHA Monitor: Marcia Andersen and Musu Fofana, MHA Office of Child and Adolescent Services

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- Collaborate with the MDQuit Center of the University of Maryland – Baltimore County (UMBC), consumers, providers, and other mental health stakeholders to promote and implement the smoking cessation initiatives at all levels in the Public Mental Health System to reduce mortality rates.

MHA Monitor: Brian Hepburn, MHA Office of the Executive Director and Gayle Jordan – Randolph, MHA Office of the Clinical Director

- Implement the provisions of the Children’s Health Insurance Program Reauthorization Act (CHIPRA) Quality Demonstration Grant from the Center for Medicare/Medicaid Services (CMS) to examine and refine Care Management Entity (CME) approaches through a multi-state (Maryland, Georgia, and Wyoming) Learning Collaborative and evaluate the impact of care management on children and families enrolled.

MHA Monitor: Al Zachik, MHA Office of Child and Adolescent Services

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CHILDREN'S PLAN

CRITERION #2: Child Mental Health System Data Epidemiology

Mental health transformation efforts and activities in the state are described within the narrative for each criterion and then referenced to the specific goal(s) in the New Freedom Commission (NFC) Reports.

PMHS DATA SYSTEM

The primary PMHS data system is currently managed by an Administrative Services Organization (ASO). On September 1, 2009, a new vendor, ValueOptions Inc. was selected to contract as the new ASO for the PMHS. Historical data from the previous vendor was transferred to ValueOptions. Historical data have also been placed at the University of Maryland Systems Evaluation Center (SEC). The SEC provides enhanced capacity for analysis of the data, particularly in relation to evaluation and outcome efforts.

The data system collects information on those who receive services in the fee-for-service system. The system is driven by a combination of authorizations and claims for mental health services. Inherent in the implementation of the PMHS is a series of extremely comprehensive data sets. Data sets on clients' service authorization and events and the provider community are available. Client information is accumulated through either the Medical Assistance (MA) eligibility file or the subsidized client data forms. Unduplicated counts are calculated by using MA numbers, Social Security numbers, and/or unique identifiers. Authorizations are made on-line and added to available data. Provider data come from provider enrollment files, which are used both for referral and for payment of claims. Finally, event and cost data are derived from claims files.

[NFC 5]

The ASO is contracted to support mental health services access, utilization review, and care coordination tasks. The PMHS data are collected and displayed by demographic, clinical service, provider, and outcome information relative to an episode of care, and also link multiple consumer records into useful "episodes of care." The PMHS data system through a series of interrelated databases and software routines can report over 200 elements for both inpatient and outpatient care. Also included among the numerous data fields, care management elements, and outcome indicators are:

- service authorizations and referrals;
- services utilized by level of care and service;
- treatment service lengths and number of units provided; and
- site visits, including record reviews and second opinion (peer) reviews of authorization.

All stored data can be retrieved and reported either in standard form, using an automated reporting system by way of custom programming, or ad hoc reports. The data may be formatted to produce monthly, quarterly, or fiscal reports. Maryland operates on

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a July-June fiscal year. Over 50 standard reports are generated to assist in general planning, policy, and decision making. The data may also be accessed to produce an unlimited range of reports via ad hoc requests. Data, when available is, shared with the Maryland Advisory Council on Mental Hygiene/PL 102-321 Planning Council.

Implemented in July 2007, information on Medicaid (MA) drug prescriptions filled by consumers in the PMHS will become available through the ASO. These prescriptions are for all medications other than HIV medications regardless of prescriber. This information is accessible to providers of mental health services. It is available to those providers with existing open authorizations to treat the consumer. The pharmacy is refreshed monthly and includes prescriptions filled during the 12 months prior to the refresh date. Information is now made available to Managed Care Organizations (MCOs), who can then communicate it to their primary care physicians. The availability of this new module has enhanced service quality and provided a rich resource to enhance data analysis efforts. [NFC 6]

An unanticipated problem resulting from PMHS implementation contributes to an undercount of persons with mental illness. The ASO Management Information System (MIS) does not capture data for individuals who receive services not reimbursed by MA and have Medicare as their only payer source. These Medicare reimbursed services cannot be subject to authorization and claims are not paid by the ASO, the two mechanisms for capturing data. Additionally, beginning July 1, 2003, claims for individuals who are qualified for federally matched MA, and have Medicare, began to be processed by Medical Assistance and the data on their utilization of Medicare reimbursed services is no longer in the ASO data system. Therefore, the data on those served in the PMHS represents an undercount.

Tables on the following pages provide data on consumers served by age group in FY 2009 and 2010. FY 2010 data shows that thus far, 117,498 individuals had claims submitted for mental health services through the fee-for-service system. Of the total 70,517 are adults, and 46,981 are children.

Access to services is critical for any mental health system. In recent years and as an ongoing strategy in the FY 2010 State Plan, MHA “continues to monitor the system for growth maintaining an appropriate level of care for at least the same number of individuals”. Data relevant to this national indicator on access to services continue to support the achievement of this target.

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The ASO MIS was utilized to produce most of the data included as performance indicators in this application. Data for FY 2009 are based on claims paid through August 31, 2010, FY 2010 data is projected based on claims paid through June 30, 2010 and historical SMI utilization. Since claims can be submitted up to twelve months following the date of service, the data for FY 2010 is still incomplete. Full year projections were not made for FY 2010. Specific diagnoses were used to define SMI. An individual was categorized as SMI if, at any time during the fiscal year, a diagnosis in the specific categories was submitted on a claim. Due to the transition of the ASO, the PMHS data is currently being processed for validation. Once data is approved for release, information will be updated and adjusted as appropriate performance indicators may change.

The MHA submitted its application to SAMHSA/CMHS for a third round of Data Infrastructure Grant in June 2009. The required Basic and Developmental Tables were submitted in December 2009. All tables will be submitted this year, including developmental tables based on new consumer survey items. Data for these come from three sources. Community data are obtained from data that results from claims, authorizations, and the Outcomes Measurement System (OMS) which are within the ASO system. Some data, such as employment status and residential status, along with detailed racial and ethnicity data, are not available from either standard claims or MA eligibility data sets. Efforts are made to obtain this information in the ASO system through requirements for registration and authorization by providers for services. The ASO information is supplemented by an annual Consumer Satisfaction and Outcomes Survey for many National Outcome Measures (NOMs), though the newly implemented OMS may allow MHA to move to client level reporting for some of these measures. Data from state operated inpatient facilities are obtained from a Hospital Management Information System (HMIS). Currently, information is abstracted from the HMIS and integrated into data from the community system to complete all required Uniform Reporting System (URS) and NOMs reporting. While this system does not use the same consumer identifiers at the ASO data system, there are elements common to both which MHA has used to establish a nearly unique identifier based on demographic variables. This identifier has been used to link data from the two systems. This system, which has been in place since 1986, is scheduled for replacement. Data for those tables reporting on individuals served and services provided are collected and reported at the person level. [NFC 5]

In addition to the ASO, MHA contracts with the Systems Evaluation Center (SEC), a component of the Mental Health Services Improvement Collaborative of the University of Maryland School of Medicine, Department of Psychiatry, Division of Services Research to assist with evaluation and data infrastructure activities. As MHA's strategic partner, SEC maintains a copy of the community services' data repository which extends back to 1999. The University of Maryland SEC has accepted responsibility for the oversight of the effort to collect the data necessary to complete the URS tables required to be included with Maryland's Mental Health Block Grant application. The SEC, ASO, and MHA are working jointly to further develop the OMS, described more fully in Criterion 5. In this coming year the SEC will continue to collaborate with MHA and key stakeholders to identify areas of interest related to the PMHS that could be

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analyzed using multiple databases. These databases include claims, authorization, the consumer satisfaction and outcomes survey, the OMS, the HMIS, Medicaid, and other state databases, as available.

Additionally, through Maryland's StateStat, MHA is also responsible for providing information on agency performance and priority initiatives. StateStat is a performance measurement and management tool implemented by the Governor to make our state government more accountable and more efficient.

INCIDENCE AND PREVALENCE FOR CHILDREN AND ADOLESCENTS

Maryland has revised its methodology for the calculation of prevalence according to the federal regulations. For children and adolescents, the recalculated Maryland poverty level changed the prevalence rates to be used in calculating number of children and adolescents with serious emotional disturbance (SED). Two estimates were used based upon the most recent information available. The estimates utilized were tied to the child poverty rate and the lowest and most upper limits of levels of functioning in the federal calculation. This translates from 5% up to 11% of the population under 18. The performance indicator under this criterion provides data for both the 5% and 11% prevalence rates. The population under 18 for each county was multiplied by the two rates cited in the federal definition.

When developing MHBG prevalence estimates for SED, Maryland relies on age specific population estimates from Maryland Vital Statistics Annual Report presented each year by the Vital Statistics Administration of the Maryland DHMH. In the past five years the number of children under age 18 in the total population in Maryland has declined by *31,000. This average loss is approximately 6,000 children per year. During this same period the total population (both adult and child) has grown slowly by approximately 5% each year (117,000). This trend results from the aging or graying of Maryland's population. The trend was not fully projected in our previous applications, which had assumed uniform growth rates for both the adult and child populations. (Future population projections relied on estimates from the Maryland State Department of Planning in collaboration with the U.S. Census Bureau)

Estimates of treated prevalence; however, were of necessity based upon a somewhat stricter definition of SED. Specific Axis I and II diagnoses codes were selected to identify the SED treated in the system. A mechanism to define levels of functioning through the data system is not available, hence the reliance on diagnoses. Slight modifications were made this year to the list of diagnoses included under the SED category. Specific pervasive developmental disorder and learning disorder diagnoses were further restricted. All data have been updated to reflect this change. As Maryland has implemented the PMHS, careful consideration has been given to maintaining services to the previously defined priority populations in both the fee-for-service and contract-based systems.

"Priority population" means those children and adolescents, for whom, because of the seriousness of their mental illness, extent of functional disability, and financial need,

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the Department has declared priority for publicly-funded services. MHA's priority population includes a child or adolescent, younger than 18 years old, with SED which is a condition that is:

- Diagnosed with a mental health diagnosis, according to a current diagnostic and statistical manual of the American Psychiatric Association (with the exception of the "V" codes, substance use, and developmental disorders unless they co-exist with another diagnosable psychiatric disorder); and
- Characterized by a functional impairment that substantially interferes with or limits the child's role or functioning in the family, school, or community activities.

Family and other surrogate caregivers should also be prioritized for services as research has shown that these persons are at high risk for the development of their own mental illnesses, particularly depression, as a result of their caring for a person with psychiatric disabilities.

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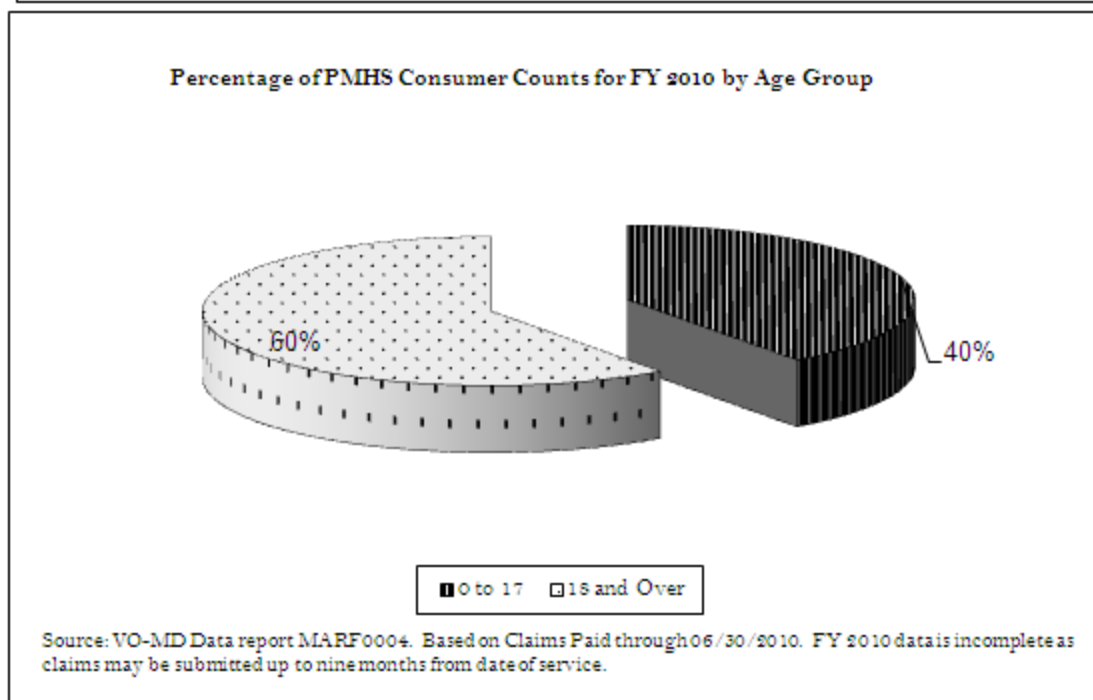
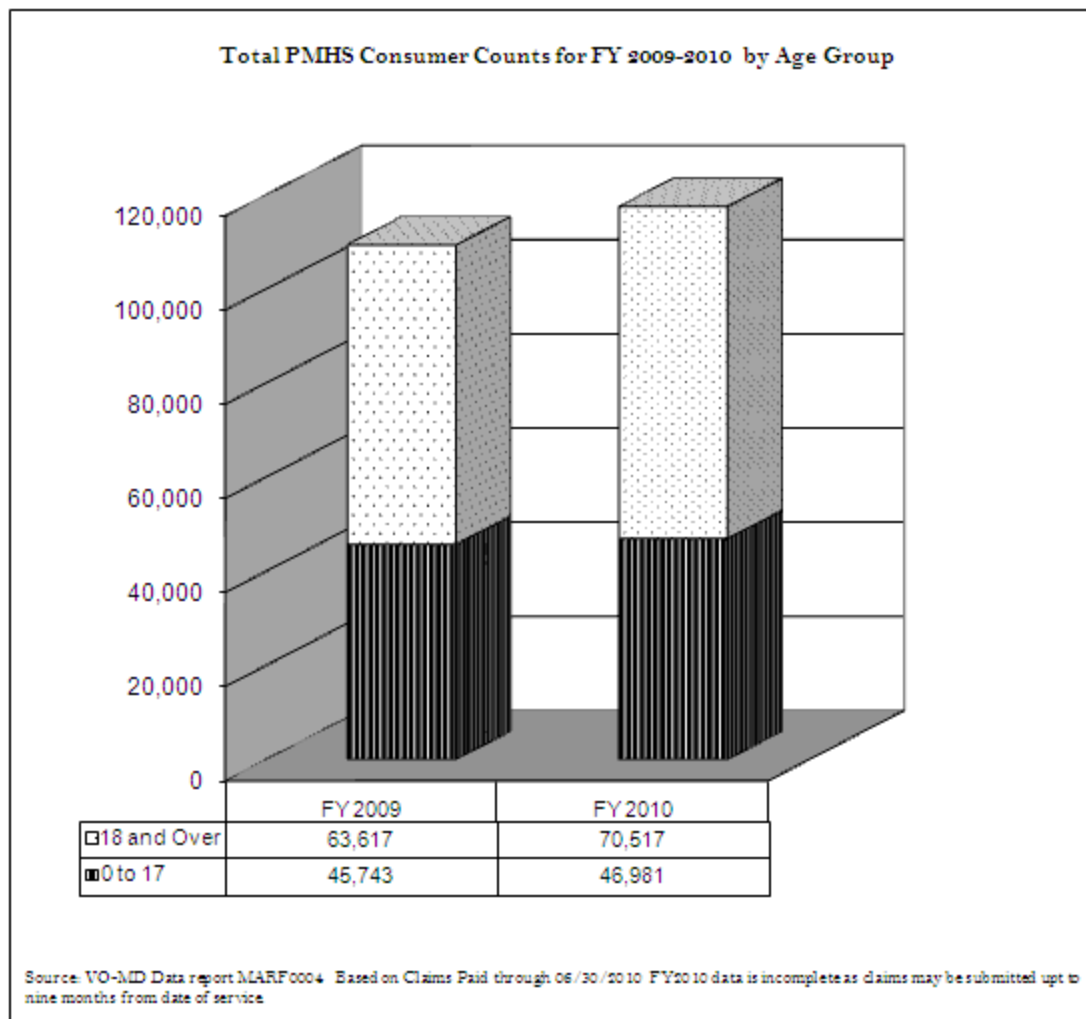
**Mental Hygiene Administration
Prevalence Estimates for Serious Emotional Disorder (SED) by County
Child and Adolescent Population**

County	Under 18 Population	Low Prevalence 5%	High Prevalence 11%
Allegany	13,277	664	1,460
Anne Arundel	122,494	6,125	13,474
Baltimore County	174,324	8,716	19,176
Calvert	21,833	1,092	2,402
Caroline	8,054	403	886
Carroll	40,617	2,031	4,468
Cecil	24,412	1,221	2,685
Charles	36,962	1,848	4,066
Dorchester	6,764	338	744
Frederick	57,641	2,882	6,341
Garrett	6,398	320	704
Harford	59,315	2,966	6,525
Howard	68,914	3,446	7,581
Kent	3,756	188	413
Montgomery	228,648	11,432	25,151
Prince George's	201,473	10,074	22,162
Queen Anne's	10,838	542	1,192
St. Mary's	26,210	1,311	2,883
Somerset	4,650	233	512
Talbot	7,059	353	776
Washington	32,931	1,647	3,622
Wicomico	21,691	1,085	2,386
Worcester	9,168	458	1,008
Baltimore City	153,154	7,658	16,847
Statewide Total	1,340,583	67,029	147,464

Data Source:

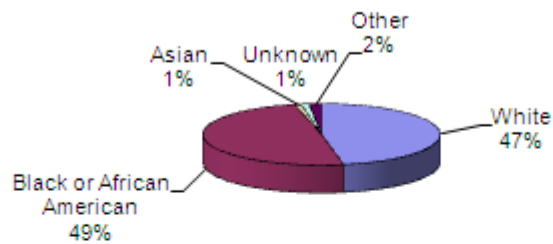
July 1, 2008 Estimated Maryland Total Population by Age Group, Region and Political Subdivision

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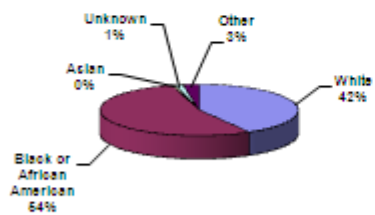


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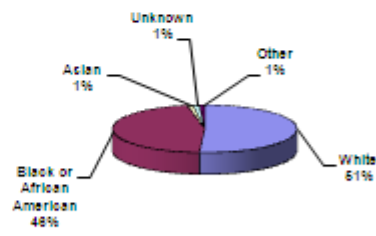
**Total Consumer Served in
in FY 2009 by Race and Age Group**



Age 0-17



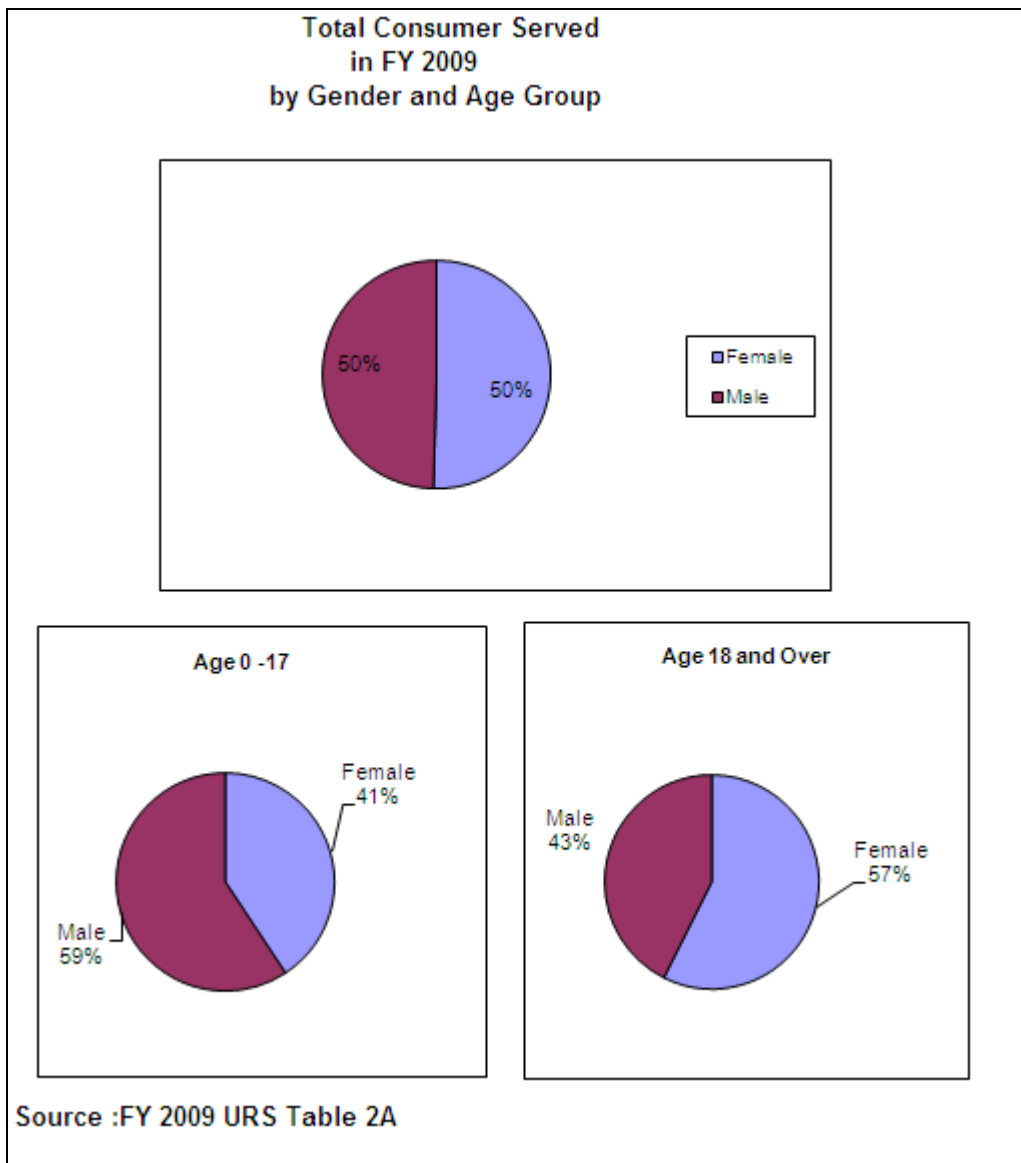
Age 18 and over



Source: FY 2009 URS Table 2A

Note: Other includes : American Indian,Native Hawaiian, Pacific Islander and those consumers with more than one race.

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SFY 2010 OBJECTIVES FOR CRITERION 2:

SERVICES FOR CHILDREN AND ADOLESCENTS

- In collaboration with CSAs and stakeholders, monitor the ASO contractual obligations and performance, monitor the system's growth and expenditures, identify problems, and, as needed, provide corrective action and maintain an appropriate level of care for at least the same number of individuals.
MHA Monitor: Lissa Abrams, MHA Office Deputy Director for Community Programs and Managed Care
- In collaboration with the Maryland Child Adolescent Mental Health Institute, the Maryland State Department of Education (MSDE), the Center for Maternal and Child Health, the Maryland Blueprint Committee, and other stakeholders, continue to build infrastructure and deliver training to improve the quality of mental health screening assessment and intervention for young children.
MHA Monitor: Al Zachik, MHA Office of Child and Adolescent Services
- MHA will work in conjunction with Department of Human Resources (DHR), Care Management Entities (CMEs), and other stakeholders to improve screening, assessment, and service delivery for children and youth in foster care.
MHA Monitor: Al Zachik and Cyntrice Bellamy, MHA Office of Child and Adolescent Services
- MHA will work in conjunction with MSDE, local school systems, and a wide range of other interested stakeholders to improve access to and quality of school mental health services provided to school-aged children.
MHA Monitor: Cyntrice Bellamy, MHA Office of Child and Adolescent Services
- In collaboration with Center for Medicare/Medicaid Services (CMS) and Maryland Medical Assistance (MA), continue implementation of the CMS-supported 1915(c) Psychiatric Residential Treatment Facility (PRTF) demonstration waiver to provide services for at least 80 children and youth and their families in four jurisdictions across the state.
MHA Monitor: Al Zachik, MHA Office of Child and Adolescent Services

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- MHA, in collaboration with the Core Service Agencies (CSAs), will continue to provide support, funding, and ongoing consultation to Maryland's mental health advocacy groups to promote and implement a series of public education and training activities to increase awareness of mental illness; mental health issues; and recovery and resiliency among children, youth, and adults.
MHA Monitor: John Hammond, MHA Office of Public Relations; Al Zachik, MHA Office of Child and Adolescent Services; and Cynthia Petion, MHA Office of Planning, Evaluation, and Training
- Enhance capacity for stakeholders to utilize PMHS data to measure service effectiveness and outcomes.
MHA Monitor: Susan Bradley, MHA Office of Management Information Systems and Data Analysis

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CHILDRENS PLAN

CRITERION #3: Integration of Children's Services

Many of the items in this section appear in Criterion #1. They are repeated here to meet the Block Grant instructions. Please refer to Criterion 1 for greater details.

Mental health transformation efforts and activities in the state are described within the narrative for each criterion and then referenced to the specific goal(s) in the New Freedom Commission (NFC) Reports.

DEVELOPMENT OF AN INTEGRATED SYSTEM OF CARE FOR CHILDREN'S MENTAL HEALTH SERVICES

As described briefly in Section II, The Children's Cabinet is Maryland's state level interagency body charged with development and implementation of an integrated interagency system of care for children, youth and families. Maryland was among the first states in the nation to legislatively create an interagency coordination body with the passage of Chapter 426 of the Acts of 1978. Subsequently, the General Assembly formalized the creation of the Subcabinet for Children Youth and Families in 1990. The existence of such an enduring interagency structure creates a highly effective venue for interagency policy development and implementation. The Children's Cabinet is composed of the Secretaries of all the major executive departments that directly provide or finance service delivery to youth and their families. These agencies include: Maryland State Department of Education (MSDE), Department of Health and Mental Hygiene (DHMH), Department of Juvenile Services (DJS), Department of Human Resources (DHR), Department of Disabilities (MDOD), and Department of Budget Management (DBM). The Governor's Office for Children (GOC) provides staffing and coordination functions for the Children's Cabinet. A working subgroup of the Children's Cabinet, the Children's Cabinet Results Team (CCRT), meets more frequently to move the work of the Cabinet forward. The CCRT membership includes Deputy Secretaries and other key members from the same agencies as the Cabinet. The director of MHA's Child and Adolescent Services is a major participant in the CCRT's work, providing staff support to the Secretary of Health and Mental Hygiene in his role on the Children's Cabinet and representing DHMH on CCRT. As a result, mental health is well represented with major input into all policy decisions and programs. The Children's Cabinet collaborates to promote the vision of the state for a stable, safe, and healthy environment for children and families. The Children's Cabinet also assesses need, establishes budget priorities, and develops interagency initiatives to address these specific priority needs.

SPECIAL MECHANISMS FOR STATEWIDE COORDINATION OF INTEGRATED CHILDREN'S SYSTEM OF CARE

Center for Medicare/ Medicaid Services PRTF Waiver - Maryland has been granted a Section 1915(c) Medicaid waiver for home and community-based services for children and youth at the Psychiatric Residential Treatment Facility (PRTF) level of care. Often referred to as the RTC (residential treatment center) Waiver, this effort is based on two high Fidelity Wraparound pilots begun in January 2006. State funding was received

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through the GOC to expand the program in FY 2007 to an additional two jurisdictions that are able to provide high-fidelity services. At the current time the waiver is open statewide and has allotted 210 slots with a waiting list. A total of approximately 80 youth are currently enrolled. Maryland is one of ten states selected to participate in the Centers for Medicare and Medicaid (CMS) sponsored PRTF demonstration which is based on using section 1915(c) federal Medicaid demonstration waivers to divert youth from psychiatric residential treatment and provide them with community-based services. The target population for the waiver is children, youth, and their families who meet the medical necessity criteria for psychiatric residential treatment facility (PRTF) admission. Regulations have been developed to govern the waiver and its operations and provider recruitment is ongoing. Children may remain in the waiver for up to 24 months with an annual review.

A major component of the implementation of the waiver includes the statewide development of Interagency Care Management Entities (CMEs). Contracts for this service were executed in January 2010. This effort is strongly integrative of the agency efforts in Maryland. It will provide care management, in addition to the PRTF waiver, {1} youth placed at the group home level by both DHR and DJS; {2} youth under auspices of SOC grants in Baltimore City; and the two System of Care grants for youth in child welfare in Baltimore City; and {3} youth under SOC grants on the Eastern Shore of Maryland.

Clearly, Maryland has a long track record in creating extensive interagency infrastructure and interagency mechanisms for sustaining and improving an integrated system of care for children, youth, and families under the broad aegis of the Children's Cabinet. Much of our success in interagency planning is based on the next element of the narrative, Maryland's commitment to youth and family involvement.

Youth & Family Involvement - The value placed on youth and family member participation continues as a major priority of the Child and Adolescent Mental Health System. This value also appears as the first element of the Interagency Strategic Plan. MHA and its partners encourage the input of youth, family members, and adult consumers across the board. A concerted effort is made to include all in the planning, development, and monitoring of the PMHS. In FY 2010, MHA will continue to fund the Maryland Coalition of Families for Children's Mental Health, a statewide child and family advocacy group, to develop local family support activities. The Coalition's mission is to inform families of children and adolescents about policy, to teach them about becoming participants in the policy and decision-making process, and to provide feedback about the operations of the Public Mental Health System. The Coalition participates on more than 22 state and local policy shaping committees. At the current time, over 50 family members are employed by the Coalition, its local counterparts, or in local child serving systems as providers of peer-to-peer support and assistance to families in navigating the system. We expect to see future increases in these numbers when the section 1915(c) Medicaid waiver becomes operational and provides reimbursement for family-to-family peer support services, youth-to-youth peer support services, and family

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and youth training delivered by peers. The new services delivered under the waiver are described in greater detail in the section on available services and supports.

A major new project of the Coalition of Families, jointly with the Maryland Mental Health Association, is the “Children’s Mental Health Matters” public awareness campaign. This project was described at length in Criterion 1.

The Coalition has conducted extensive research over the years, including studies using focus group design, of parents involved with custody relinquishment, the juvenile justice system, transition-age youth (TAY) and families of young children engaged with the early childhood education system. These studies have been described in past year’s plans and they provide an excellent and highly effective basis to support advocacy and policy initiatives designed to improve the child and adolescent system of care. In addition, in FY 2004, the Coalition established a Family Leadership Institute (FLI) which has continued producing new advocates every year since. FLI provides a six-month training program for families in becoming advocates in their communities and the state. Twenty families participated in the first Institute. The fifth Family Leadership Institute was held this year with 20 graduates, increasing the total number of trained family advocates to 115 over the five years of the Institute implementation.

Youth MOVE - In June 2007, Maryland initiated its Youth MOVE (Youth Motivating Others through Voices of Experience) program which provides training for youth to be active participants and leaders in seeking services for themselves and for the community of youth. Maryland’s effort is based on the national model. Information is available at (<http://www.tapartnership.org/youth/YouthMOVE.asp>).

Last year, MHT-SIG established Youth MOVE Maryland by hiring a statewide coordinator housed within the Innovations Institute (described in a following section). Youth MOVE has been funded in 13 of the state’s 24 jurisdictions. The further statewide roll-out and continued efforts will be sustained through the new Systems of Care (SOC) grant award. Accomplishments include the following: creation of a Youth MOVE MySpace page and brochure; several meetings with senior state officials; and a number of county specific social marketing activities.

Maryland’s Blue Print Committee - A major outgrowth of Maryland’s family involvement philosophy was the development of the Maryland Blue print for Children’s Mental Health. This ongoing strategic planning effort was developed at the request of our statewide family organization, originally in 2003, and the Blueprint was updated last year. It is a five-year strategic plan which extends the work of the 2003 Blueprint to address the mental health needs of children, youth and their families. The guiding philosophy of care found in the Public Health Model, with its emphasis on the health of an entire population beginning with health promotion, prevention and early intervention, is central to the 2009 update. The revised vision and mission, as well as the recommendations and suggested strategies themselves, are rooted in the broader public health approach to mental health.

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Six major themes emerged which became the basis for recommendations and suggested strategies. Within each theme, the recommendations were prioritized. The six themes and the most highly prioritized recommendation in each are listed as follows:

- Mental Health Promotion, Prevention and Early Intervention
 - Increase and coordinate mental health promotion efforts, increasing protective factors and decreasing risk factors through individual and community education for all age groups across all jurisdictions
- Family and Youth Partnership
 - Ensure that Family and Youth are equal partners at every level of statewide and local decision making throughout each phase of policy, program, and evaluation in all jurisdictions
- Infrastructure Development
 - Develop sustainability for core levels of services, supports, and opportunities in each jurisdiction (as proposed in Continuum of Services and Supports below)
- Workforce Development
 - Strengthen services by providing adequate pre-service and in-service training, resources, and leadership to all those who provide direct care to children, youth and their families across disciplines and populations
- Access to Care and Opportunities
 - Provide consistency in policy, practice, and funding across agencies and throughout local jurisdictions
- Continuum of Services and Supports
 - Define and develop an accessible baseline, or foundation of services and supports, in every jurisdiction in Maryland

The Maryland Child and Adolescent Mental Health Institute - A major outgrowth of the original Blue Print Committee process was the development of the Maryland Child and Adolescent Mental Health Institute. The Institute is a joint project of Johns Hopkins and the University of Maryland (UM) Schools of Medicine. A number of key related projects run by the Institute include: {1} a SAMHSA-funded effort to reduce seclusion and restraint in state-operated child and adolescent mental health facilities; {2} a SAMHSA-funded Child Trauma Center; and {3} a project focused on implementation of Treatment Foster Care implementation, a process begun under the National Institute of Mental Health (NIMH)-SAMHSA Science to Service grant. In addition, a special focus has been placed in partnership with DHR and the UM School of Social Work on development of trauma-informed care and evidence-based Cognitive Behavioral Therapy for children and youth in the foster care system. Funding from the MHT-SIG has been provided through the Institute to the UM Center for School Mental Health Assistance, one of only two national centers on school mental health funded by the federal government, to study the educational needs of children in child welfare.

- In addition to the above, the Maryland Child and Adolescent Innovations Institute, of the University of Maryland Division of Child and Adolescent Psychiatry, was initiated in 2005 to assist the State of Maryland, the Children's Cabinet, the Governor's Office for Children (GOC), Maryland jurisdictions, and the state's child-serving agencies to support efforts in improving access, services

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and outcomes for families of children with intensive needs. Innovations Institute seeks to assist the state of Maryland and local jurisdictions with obtaining skills, interpreting new knowledge, and adapting policy and practice to ensure that Maryland's children, youth, and families achieve wellness through family-driven, youth-guided, culturally and linguistically competent, and individualized quality care within a system of care. The Innovations Institute is funded by the Governor's Office for Children (GOC).

- The Johns Hopkins University School of Medicine offers a broad range of research, educational, and clinical resources. The Department of Psychiatry and Behavioral Sciences has over 200 full-time faculty members and an extensive program of research supported by multiple funding sources, including over \$38 million annually in National Institutes of Health (NIH) grants. The Division of Child and Adolescent Psychiatry consists of 40 full-time faculty members who are located in diverse clinical settings. The faculty are committed to training clinical researchers in the following areas of interventions research with children and adolescents: 1) efficacy studies evaluating new or available but un-validated medication and/or psychosocial treatments; 2) effectiveness studies of empirically supported treatments applied in diverse populations and settings; 3) safety and adverse effects of psychotropic medications, particularly during long-term treatment; and 4) methodological approaches and techniques that inform the specificity of treatment to identify which treatments work best for which individuals. The research environment in the Division of Child and Adolescent Psychiatry is very collaborative in nature, offering many opportunities and resources.

INTEGRATION OF MENTAL HEALTH WITH SOCIAL SERVICES, STATE AND LOCAL EDUCATIONAL SYSTEMS, JUVENILE JUSTICE AND SUBSTANCE ABUSE SERVICES

Details of the more specific interagency initiatives are presented below. The service sectors identified in Criterion 3 specifically for integration with mental health include: {1} social services; {2} education (including, but not limited to, special education); {3} juvenile justice; and {4} substance abuse services. These are discussed in the order they appear in the federal statute.

Social Services - The social service sector in Maryland is primarily housed in the Department of Human Resources (DHR). For child and adolescent planning purposes, the majority of social services are administratively located in the Social Services Administration (SSA). The principal functions of SSA are child welfare focused including child protection, kinship care, formal custodial placement of children in a variety of out of home placements, family reunification, and adoption/post adoption services. It is important to note that the juvenile court plays a significant role in interfacing with the social service sector through its dependent youth docket, in addition to the role it plays in the juvenile delinquency sector. Both juvenile and social services will be discussed again in the subsequent section on housing. Collaboration with social service providers is particularly important given the high prevalence of mental health

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disorders among children who are in custody of the state's child welfare system. Local social service agencies in each jurisdiction are called Departments of Social Services (DSS). MHA tracks the percentage of selected categories of youth in the child welfare systems who receive services via the PMHS as a performance indicator.

- **“Place Matters”**--A current major priority of DHR is the “Place Matters” campaign. The agency joined with the Annie E. Casey Foundation’s Casey Strategic Consulting Group to reform foster care in the state. DHR is spearheading a three-year effort to bolster 1,000 new foster family homes by 2010 so that children live in closer proximity to their family members and their communities. Specific recruitment goals for each region of the state are guiding the outreach. Key Performance Measures for Place Matters include: {1} reducing the number of children in out-of-home care; {2} reducing the number of children in group homes; {3} increasing the number of children placed in their home jurisdiction; {4} increasing the number of children who reunite with their family; and {5} increasing the number of adoptions.
- **“Other DHR”** - Other DHR social services that are housed outside of child welfare, which also come into play in planning and delivery, include homeless services, domestic violence services, victim services, adult services, and Medicaid eligibility services, (notably for Medicaid waivers). It is important to note that child care services, typically considered a social service, are administratively housed in Maryland within the Department of Education. As a result, these services will be discussed subsequently in conjunction with early childhood education. For those youth and young adults in the transitional youth age range, the full array of adult oriented social services also become a part of the overall system of integrated services required.
- **“MD CARES & Rural CARES”** – Funded through Two SAMHSA system of care grants, MD CARES and Rural CARES projects are key child welfare collaborations in major geographic and population centers of the State.. These projects will develop a cross-agency partnership that blends family-driven, evidence-based practices within mental health and child welfare to better serve this high risk population. In Maryland there are approximately 10,100 children in foster care, of which approximately 6,100 are from Baltimore City. Grant funds will be used to expand and support “wraparound” services to foster children in their communities. Wraparound services provide a comprehensive array of home and community-based services to maximize the strengths of families, natural support systems, and community resources. These services are different from traditional "one size fits all" programs and expensive residential care.
- **Crisis Stabilization and Response** - A related joint venture with DHR that first appeared in last year’s plan, is the creation of a mental health crisis response and stabilization system designed to help respond to children in foster care placements and intervene in the home setting so that psychiatric crises and resulting hospitalization do not result in the disruption of the child’s residential placement. This initiative was funded in the Governor’s budget and approved by the General Assembly to commence in FY 2009. Program start-up began in selected jurisdictions in September 2008. Nine service provision areas covering 16

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counties have been initiated. These include the Lower Shore region; Mid-Shore region; Allegany, Garrett, Washington, Baltimore, and Anne Arundel Counties; and Baltimore City. During the upcoming year jurisdictions plan to hold extensive trainings of local first responders, police and Emergency Management System (EMS) staff, about the special needs of foster families. Harford and Prince George's Counties originally planned for statewide implementation. However, further expansion of this project has unfortunately been curtailed due to budget limitations.

Educational services (including those provided by local schools and the Individuals with Disabilities Education Act (IDEA) - MHA continues its extensive work with the Maryland State Department of Education (MSDE), both in regard to strengthening student support services for students in regular classrooms and in special education settings governed by the requirements of the Individuals with Disabilities Education Act (IDEA). MHA and MSDE collaborate to provide services to children and youth and to recruit qualified mental health providers for schools and the community. An extensive array of school-based mental health services are available for students enrolled in regular education and in special education. As noted earlier, there has been a considerable increase over the past several years in school-based mental health services and school health centers that address a narrow band of adolescent somatic and behavioral health.

MHA will focus on outcomes for students identified with emotional disturbance in Maryland's school systems. This process directly addresses the specific needs of the most highly involved youth identified under the entitlement provisions of the Individuals with Disabilities Education Act (IDEA). A highly successful series of forums was held in the spring of 2008, which highlighted some of the challenges faced by this group of students. MSDE tracks a number of key data elements on students identified under IDEA with emotional disturbance. These data elements include the dropout rates, suspension/expulsion rates, and preliminary data on high school academic performance in English and Algebra. These data reveal troubling trends for all the students, particularly the transition-age youth, with mental health needs. More than 49 percent of nearly 9,000 students identified with emotional disturbance dropped out of Maryland schools in 2006, capping a rising trend of more than six percent across the past four school years. Prior to dropping out of school, students with emotional disturbance experience a disproportionately greater number of suspensions and expulsions than do other students with disabilities. Although students with emotional disturbance comprise slightly over eight percent of all students in special education, they account for 52 percent of all suspension/expulsion related disciplinary actions for special education students. This factor is all the more staggering when one considers that so many dropout of school prematurely. Academic proficiency testing in Algebra and English II reveals students scoring in the low 30 percent proficiency range compared to all Maryland high school students, whose aggregate scores are twice as high, registering over 60 percent proficiency on these assessments. To compound an already troubling picture, it must be noted that African American students are disproportionately much more likely to be identified as emotionally disturbed in Maryland schools. African Americans constituted over 56% of all students identified with emotional disturbance in 2006 while representing

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only 33% of the school-aged population (MSDE PowerPoint- “Meeting the Needs of Students with Emotional Disturbance in Schools”--April 28th, 2008).

Early Childhood Mental Health - The goal of the Maryland Early Childhood Mental Health Initiative is to increase the numbers of children who enter kindergarten ready to learn. Maryland has moved to a statewide assessment of children who enter kindergarten - the Work Sampling System - which provides a status report, at the school and county levels, of children and their school readiness. According to the criteria employed, Work Sampling System scores represent percentages of students who consistently demonstrate skills, behaviors, and abilities needed to meet kindergarten expectations successfully. The Work Sampling data are compiled in seven domains and also create a composite readiness score. Over time these scores represent the level of progress the state has made in achieving its goal of increasing the number of children entering school ready to learn.

The strategy for early childhood mental health is to integrate mental health services into existing early childhood programs (children 0 to 5 years), to incorporate supports into existing early childhood programs, and to promote and support the integration of early childhood mental health services within other settings. The mental health component of the Maryland Infant and Toddler Program, which provides services for young children governed by IDEA, is strengthened by the activities of the Early Childhood Mental Health Initiative. Additionally, the Initiative supports the provision of mental health services in day care services as well as federally-funded Head Start programs.

The Maryland State Early Childhood Mental Health Steering Committee provides direction to the Initiative. The Steering Committee is composed of a wide variety of organizations including: MHA’s Office of Child and Adolescent Services; Maryland Coalition of Families for Children’s Mental Health; MSDE; Governor’s Office for Children; DJS; Maryland Insurance Administration; Mental Health Association of Maryland; CSAs; Local Management Boards; University of Maryland Training Center; and other child serving agencies.

Findings from the recent evaluation of the pilot of early childhood mental health consultation with childcare providers indicated that that on-site consultation to child care programs delivered by interventionists who were knowledgeable about child development, individualized consultation for children at risk of being expelled from their child care programs, and consultation to providers about classroom-wide behavior management strategies had a number of positive effects. These effects included substantial decrease in expulsion for at-risk children, strong gains in social skills, reductions in children’s problem behaviors, changes in teachers’ behaviors, and improvement in the classroom environment. Based on the results of the pilot project evaluation, support from agencies, providers and families, and the success of the FY 2007 expansion of early childhood mental health consultation, MSDE received \$2.5 million for FY 2008 to further early childhood mental health screening, prevention, and intervention for preschool children at risk of developing emotional and mental health disorders. This funding will ensure that consultation is available in all jurisdictions.

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School Based Mental Health - MHA continues its extensive work with the Maryland State Department of Education (MSDE), both in regard to strengthening student support services for students in regular classrooms and in special education settings governed by the requirements of the Individuals with Disabilities Education Act (IDEA). MHA and MSDE collaborate to provide services to children and youth and to recruit qualified mental health providers for schools and the community. There has been a considerable increase in school-based mental health services over the past several years. For example, mental health services are available in over 120 public schools in Baltimore City and in six schools in Baltimore County. There are currently 61 school-based health centers across the state, each of which provides somatic services. Approximately half of the centers also provide mental and behavioral health services.

The Blueprint School Mental Health Committee completed a statewide assessment of expanded school mental health availability in Maryland's 24 local jurisdictional school systems.

- **Positive Behavioral Interventions and Supports (PBIS)**-- Additionally, Maryland law requires elementary schools with suspension rates over 18% to implement the PBIS, or an alternative behavioral modification program, to reduce suspensions. MSDE, in partnership with Sheppard Pratt Health System and Johns Hopkins University's Bloomberg School of Public Health, oversees and supports the statewide implementation of PBIS in Maryland. The partnership, known as PBIS Maryland, is responsible for providing training and technical assistance to local school systems. Each summer, the PBIS Maryland hosts a Training Institute for new teams and local school systems host a number of local/regional Training Institutes for their implementing schools. An increasing number of schools are choosing to use this program because of its success in improving school climate. The program has been successful in decreasing the number of suspensions and expulsions as well as behavioral referrals to special education. As of 2009, a total of 648 schools will be trained in PBIS and 568 schools actively implementing PBIS in Maryland
- MHA's Work Force project undertaken with the MSDE is described in greater detail in Criterion 5.
- Specialized efforts with the Early Childhood Educational sector and, for transition-age youth, with the Division of Rehabilitation Services (DORS), housed within MSDE, are described in subsequent sections.

Juvenile Services – The Mental Hygiene Administration (MHA) consults and collaborates with the Department of Juvenile Services (DJS) to coordinate mental health services within their juvenile detention centers. The mental health programs focus on the needs of youth in the care of DJS prior to adjudication and disposition by the juvenile court.

The MHA Child and Adolescent staff provide training for DJS direct care staff on an as needed basis. In FY 2010, the Director of Child and Adolescent Services began a

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Psychopharmacology Learning Collaborative consisting of psychiatrists who provide services to youth in the juvenile justice system. The focus of the Collaborative is to examine the use and administration of psychotropic medication to youth in custody.

Youth in the juvenile justice system will benefit from the implementation of Interagency Care Management Entities (CMEs) statewide. Contracts to two private vendors have been awarded to deliver services. This effort is strongly integrative of the agency efforts in Maryland as it will provide care management in addition to the PRTF waiver, for youth placed at the group home level by both DHR and DJS. The CME serves as the clinical home for high utilizing populations of children with serious mental health challenges. The focus is on strength-based service planning that is coordinated across agencies and providers, intensive care management, and home and community based alternatives to residential and hospital care.

Substance Abuse Services including co-occurring disorders - DHMH is the agency responsible for mental health, substance abuse, developmental disabilities, AIDS, maternal and child health, and all the programs offered through the State Medical Assistance Plan. There is an ongoing need for coordinating mechanisms within the Department itself in order for DHMH to fulfill its role as an interagency partner with the other Departments of the Children's Cabinet. The coordination of services for substance abuse, as well as developmental disabilities, with services offered to children and youth for mental health problems, is a critical issue within the DHMH coordination process. These needs all fall under the category of youth with special health care needs, and the primary systemic coordinating effort is the Special Needs Advisory Committee.

In the past, Maryland has emphasized cross training of staff and coordination of services as a means of providing access to services by individuals needing both mental health and substance abuse services. Staff coordinators from MHA and ADAA work with the special needs coordinator from the child's HealthChoice MCO when a child with co-occurring diagnoses requires enhanced coordination efforts. A number of existing mental health treatment and rehabilitation programs, as well as programs established through the DHMH Alcohol and Drug Abuse Administration (ADAA), have developed dual diagnosis capability and are able to offer substance abuse treatment services to individuals with mental illnesses.

The Secretary of the Department of Health and Mental Hygiene (DHMH) has also demonstrated commitment to co-occurring disorders by appointing an administrative officer from his office to work with MHA and ADAA. As a result of coordination through this position, a state-level leadership team has been convened to provide leadership toward enhanced service coordination across systems. There is now a State Charter, reflecting the state's ongoing development toward service integration across the systems. Additionally, within DHMH, legislation established the Office of the Deputy Secretary for Behavioral Health and Disabilities. This Office includes responsibilities for developing a system of services for individuals with co-occurring disorders, to address systems change and to identify and implement specified treatment and supports.

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The majority of the women with co-occurring disorders in the justice system have children and a smaller population is pregnant while incarcerated. MHA was instrumental in development and implementation of the TAMAR's Children Program which addressed the needs of the women and their children. In 2007, MHA collaboratively worked with the Department of Public Safety and Correctional Services, the Administrative Office of the Courts, the Alcohol and Drug Abuse Administration, the Family Health Administration, Baltimore Mental Health Systems, Inc. and the Archdiocese of Baltimore to create a new statewide diagnostic and transitional program for pregnant women who are at least 18 years of age who might otherwise be incarcerated. As a result of this collaborative partnership, a new program, the Chrysalis House Healthy Start Program, was created. This program, funded through state general funds, consists of a 16-bed diagnostic and transitional facility (in the former location of the Tamar's Children Program) and serves pregnant and post-partum women and their babies.

After the newborn's birth, the mother and baby remain in the residential facility and receive a comprehensive array of services. Services include: medical care through contract with a health care organization; mental health treatment which includes trauma and attachment-based treatment interventions; substance abuse treatment and co-occurring treatment services; legal services; parenting and childcare services which include involvement from the Healthy Start and Family Tree Programs; housing; after hours residential support; health education; and other support services.

Pregnant women may be referred by the courts, the state, Defense Attorney, or DHMH. A comprehensive assessment is conducted by a licensed clinician and an individualized treatment plan is developed between each woman and the treatment team.

Also in FY 2008, MHA continued to offer and/or provide consultation to state and local agencies serving pregnant and post-partum women and their children on mental health and trauma. MHA continues to fund outreach, case management, and housing assistance to graduates of the Chrysalis House Healthy Start Program through funding provided to Prisoner's Aid Association. [NFC 2]

Health and Mental Health Services

Since DHMH is the agency responsible for mental health, substance abuse, developmental disabilities, AIDS, child and maternal health, and all the programs offered through the State Medical Assistance Plan, there is an ongoing need for coordinating mechanisms within the Department itself in order for DHMH to fulfill its role as an interagency partner with the other Departments of the Children's Cabinet. The coordination of services for substance abuse, as well as developmental disabilities, with services offered to children and youth for mental health problems, is a critical issue within the DHMH coordination process. These needs all fall under the category of youth with special health care needs, and the primary systemic coordinating effort is DHMH's Special Needs Advisory Committee. Staff coordinators from MHA and ADAA work with the special needs coordinator from the child's HealthChoice MCO when a child with co-occurring diagnoses requires enhanced coordination efforts. Efforts to support

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initiatives at the county level to implement the Integrated Systems of Care for Consumers with Co-Occurring Mental Health and Substance Use Disorders model of best and evidence-based practices and the State's involvement in the SAMHSA National Policy Academy are discussed under Criterion 1.

DEFINED GEOGRAPHIC AREAS FOR PROVISION OF CHILD SERVICES

At the jurisdictional or local level, Local Management Boards (LMBs) have been created in each of the 24 jurisdictions with the responsibility for coordinating a wide variety of services provided to children, youth, and families. These entities operate in ways similar to the CSA function described under Section I, Regional/Sub-State Programs. In many jurisdictions the LMB has a member on the CSA and vice versa, resulting in the integration of the efforts of LMBs and CSAs, who are responsible for mental health which is an essential component of the child and adolescent service system in Maryland.

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SFY 2011 OBJECTIVES FOR CRITERION 3:

INTEGRATION OF CHILDREN'S SERVICES

- MHA will work in conjunction with Department of Human Resources (DHR), Care Management Entities (CMEs), and other stakeholders to improve screening, assessment, and service delivery for children and youth in foster care.
MHA Monitor: Al Zachik and Cyntrice Bellamy, MHA Office of Child and Adolescent Services
- Implement the provisions of the Children's Health Insurance Program Reauthorization Act (CHIPRA) Quality Demonstration Grant from the Center for Medicare/Medicaid Services (CMS) to examine and refine Care Management Entity (CME) approaches through a multi-state (Maryland, Georgia, and Wyoming) Learning Collaborative and evaluate the impact of care management on children and families enrolled.
MHA Monitor: Al Zachik, MHA Office of Child and Adolescent Services
- MHA, in collaboration with Maryland Department of Disabilities (MDOD), Department of Human Resources (DHR), Maryland State Department of Education (MSDE), and other stakeholders, will develop integrated home and community-based services and supports for youth and young adults in transition through the Healthy Transitions Initiative demonstration project in Washington and Frederick Counties.
MHA Monitor: Tom Merrick, MHA Office of Child and Adolescent Services and Steve Reeder, MHA Office of Adult Services
- In collaboration with the Maryland Child Adolescent Mental Health Institute, the Maryland State Department of Education (MSDE), the Center for Maternal and Child Health, the Maryland Blueprint Committee, and other stakeholders, continue to build infrastructure and deliver training to improve the quality of mental health screening assessment and intervention for young children.
MHA Monitor: Al Zachik, MHA Office of Child and Adolescent Services
- In collaboration with Center for Medicare/Medicaid Services (CMS) and Maryland Medical Assistance (MA), continue implementation of the CMS-supported 1915(c) Psychiatric Residential Treatment Facility (PRTF) demonstration waiver to provide services for at least 80 children and youth and their families in four jurisdictions across the state.
MHA Monitor: Al Zachik, MHA Office of Child and Adolescent Services

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CHILDRENS PLAN

CRITERION #4: Rural Populations and Services to the Homeless

Mental health transformation efforts and activities in the state are described within the narrative for each criterion and then referenced to the specific goal(s) in the New Freedom Commission (NFC) Reports.

TARGETED SERVICES FOR RURAL POPULATIONS

Definition of Rural Areas

Rural counties have historically been defined in Maryland as those with a population of 35,000 or less. Six counties continue to meet this criterion. Source: U.S. Census Bureau, Estimated Maryland Total Population by Political Subdivision, July 1, 2008 - Maryland Vital Statistics Annual Report 2008.

Maryland's definition was reviewed relative to the more complicated definitions of rural used by the U.S. Census Bureau. For Census 2000, the Census Bureau's classification of "rural" consists of all territory, population, and housing units located outside of urbanized areas (UAs) and urban clusters (UCs). The Census Bureau also looks at the population density with core census blocks of at least 1,000 people per square mile or surrounding census blocks with an overall density of at least 500 people per square mile. Many counties and metropolitan areas are split with UAs and UCs, often mixed with more rural areas. Based on population density alone, several other counties in Maryland, beyond the six, might be considered rural. However, other factors, including growth rate and proximity to major metropolitan areas (emerging bedroom communities), make these counties appear less rural. Based upon these factors, the six counties with populations under 35,000 will remain Maryland's defined rural areas for purposes of this application, while recognizing that pockets of "rural" areas exist in other counties.

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Of the six Maryland counties that qualify under this definition, one rural county—Garrett—is the western-most jurisdiction in the state, and the other five—Caroline, Dorchester, Kent, Somerset, and Talbot Counties—are on the Eastern Shore. In recent years, several Eastern Shore counties have developed past the 35,000 threshold. Typically, as a rural county develops beyond the 35,000 threshold, it experiences growth in housing, commerce, and average household income that makes it more similar to the rest of the State. (** Talbot County, with 36,215 slightly exceeds this threshold. Please see discussion of Talbot County on following page.)

Rural County Population -- March, 2009	
Caroline	33,138
Dorchester	31,998
Kent	20,151
Somerset	26,119
Talbot**	36,215
Garrett	29,698

Source: U.S. Census Bureau, Estimated Maryland Total Population by Political Subdivision as of March, 2009

While the Mental Hygiene Administration will continue to utilize the foregoing definition of rural counties for purposes of this Mental Health Block Grant Application, the Office of Health Policy and Planning of the Maryland Department of Health and Mental Hygiene in June 2007 published *The Maryland Rural Health Plan* which provides a broader discussion of rural health issues in Maryland. The following are excerpts from that plan to assist us in identifying and addressing rural mental health issues in this analysis.

“The challenges to providing quality health care services and delivery to rural Maryland largely result from their geographic isolation and lack of the critical population mass necessary to sustain a variety of primary and specialty services. Efforts to address health care disparities in rural areas are often made difficult by struggling economies and limited financial and human resources.”

“Compared with the state overall, Maryland’s rural communities tend to have fewer health care organizations and professionals, higher rates of chronic disease and mortality, and larger Medicare and Medicaid populations. Evidence indicates that rural populations fare worse in many health and economic indicators, and do not receive the same quality, effective, and equitable care as their suburban counterparts. Rural populations tend to be older and exhibit poorer health behaviors such as higher rates of

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smoking and obesity, relative to the State, although there is variability in health behaviors among rural communities.”

The DHMH Office of Rural Health convened a steering committee to create the Maryland Rural Health Plan. Among the top priority areas for rural health in Maryland identified by the Steering Committee were behavioral health (mental health and substance abuse) and improvement in behaviors leading to a healthier lifestyle.

For purposes of data analysis and comparison, all Maryland jurisdictions where at least two-thirds of the census tracts are classified as rural by the federal Office of Rural Health Policy (ORHP) are included in the “federally designated rural” group. These jurisdictions tend to fare worse in the health and economic status because they are generally more isolated and have smaller and older populations than the other jurisdictions. The ORHP classifies the following three additional counties in addition to the previously identified six jurisdictions as rural: Allegany County (with 72,238 population); St. Mary’s County (with 101,578 population); and Worcester County (with 49,274 population-year round/non summer). It is worthwhile to note that rural issues apply to other areas beyond the six most rural counties discussed in this rural section of Maryland’s mental health block grant analysis.

**Talbot County is an excellent example of a county that is in the process of transforming from a rural to non-rural area. On July 1, 2003 the population was 34,670. On July 1, 2007, the last year in which official age specific population was available, the number increased to 36,215 exceeding Maryland’s self defined “rural” threshold of 35,000 by 1,215 -1,193. Projections indicate that the population of Talbot County continued to increase approximately 0.06% in 2008. For purposes of this year’s block grant application, we will continue to include Talbot County among the six rural counties – (Utilization data from all six counties are used in the block grant performance indicator). Talbot County now has an average per capita personal income of \$56,775, up from \$51,947 in 2006, (Department of Business and Economic Development <http://www.choosemaryland.org/factsandfigures/demographics/incomedata.html>).

The five Eastern Shore rural counties have personal per capita incomes ranging from a low of \$24,053 in Somerset County to the high of \$56,775 in Talbot County, compared to a statewide average per capita personal income of \$48,091. The demographics of Somerset County and most of the Shore counties also reflect issues affecting rural areas. As the second smallest county in the state, Somerset County’s population actually increased slightly by +103 individuals after a decline in a recent previous year according to the July 1, 2008 DHMH Vital Statistics estimates. Somerset County’s 2004 household median income was one of the lowest in the State at \$33,700. Statewide household median income was \$70,545 over the past five years, the number of Medical Assistance Program enrollees has risen (Economic updates from Maryland Manual 2005 estimate printed 6/24/08).

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Garrett County, in western Maryland, provides a useful example of how rural communities differ from jurisdictions in more rapidly developing areas of the State. Garrett County has one of the lowest per capita incomes (\$29,820) of the State's 24 subdivisions. The 2010-2011 Core Service Agency (CSA) Plan notes that Garrett County has 819 families, or 9.8% of the 8,354 families who live in poverty. In 2007, the median household income was \$40,150 (Maryland Department of Business and Economic Development): Garrett County ranks 21st out of 24 counties in the state, for total personal income. Unemployment rates in Garrett County are almost double that of the State of Maryland. According to the July 2007 Maryland Department of Labor statistics, the annual average unemployment rate ranged from 4.5%-4.8% in one year. Current data for April 2009 estimates a 7.3% unemployment rate in Garrett County compared to a 6.6% statewide rate, (Source US Department of Labor). In Garrett County, of the adults in the age group 25 and over, 7% have less than a ninth grade education or no diploma; 79.2% have a high school or higher education. (Statewide Web-based data indicate that in March 2009 a total of 6,345 out of the total county population of 29,627 were Medicaid eligible.) The current plan indicates 18.6% of the county residents, among the highest of Maryland jurisdictions, are enrolled in Medical Assistance.

In its FY 2009 CSA Plan Update, Garrett County is described as a, rural, mountainous county in the northwestern most corner of Maryland. This area of the Appalachian Mountains has high elevations with severe winter conditions. The average yearly snowfall is over seven feet. The majority of roads are winding, the nearest large city with mental health services is Cumberland, Maryland, located in Allegany County. Limitations, typical of rural areas exist in availability of transportation, access to healthcare and health information for a number of socioeconomic, geographic, educational, and cultural reasons. Low education levels create a barrier to seeking and understanding health information. However, in April 2009 access to primary health care services was improved when a new permanent Federally Qualified Health Center (FQHC) opened on property adjacent to the Garrett County Health Department and a major mental health outpatient clinic (OMHC). There was a 5.6% increase for persons served in the OMHC from 2008 to 2009. The plan notes that some of the OMHC increases resulted from more children 6-12 being served. In FY 2011, the CSA will continue to promote a mental health service delivery system which is locally driven and addresses housing, employment, transportation, and community support for consumers and their families.

Use of Technology

The best example of the use of technology in Maryland is the statewide launch of The Network of Care. The Network of Care is an information Website cited as a "best practice" for the use of technology in the President's New Freedom Commission Report on Mental Health. The site contains a listing of services; a library of mental health articles; a list of support and advocacy organizations; legislation; and a personal folder/advance directive/Wellness Recovery Action Plan (WRAP) feature. The goal is to provide simple and fast access to information for persons with mental illnesses, caregivers, and service providers. The Website was first piloted in Worcester and Anne

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Arundel Counties. The official statewide launch was held at the annual summer conference of On Our Own of Maryland, Inc. (OOOMD) in June 2008. Phase II of the Network of Care initiative reached out to consumers in all of Maryland's 24 jurisdictions who now have access to information and resources in their communities. The Maryland Network of Care for Behavioral Health continues to enhance Maryland residents' ability to access consumer driven and recovery oriented information regarding available mental health services. The Maryland Network of Care for Behavioral Health has recorded 294,006 sessions from its May 30, 2008 launch date through August 31, 2009. Since its March launch through August 31, 2009, the site has recorded 9,544 sessions.

The Network of Care site added a comprehensive Veterans' portal to help service men and women returning from Iraq and Afghanistan with behavioral issues obtain access to services. In response to the increasing numbers of returning veterans, Maryland was the first state in the country to launch the Network of Care for Veterans & Service Members. This site, kicked off by Lieutenant Governor Anthony Brown on March 31, 2009, is a one-stop-shop arrangement, bringing together critical information for all components of the veterans' community, including veterans, family members, active-duty personnel, reservists, members of the National Guard, employers, service providers, and the community at large. This public service is an attempt to bring together critical information for all components of the veterans' community, including veterans', family members, active duty personnel, reservists, members of the National Guard, employers, service providers, and the community at large.

In FY 2010, MHA collaboration with Mental Health Transformation Office (MHTO) and CSAs, to improve implementation and provide training on Network of Care improved outcomes will include: Web-based platform purchased and installed throughout Maryland, utilization of site tracked, improved user friendliness, mental health community informed regarding availability of Web system, consumers trained in the utilization of personal health record features, and training in use of individual advance directives.

Since November 2008, the Mental Hygiene Administration and the University of Maryland's Department of Psychiatry has partnered with three Core Service Agencies (CSAs) to provide psychiatric care in seven rural counties in the state. This tele-psychiatry program allows individuals living in rural areas to see a psychiatrist in Baltimore without traveling from their home communities. Clinical services began in December 2008.

In FY 2011 Maryland established Telemedicine for rural areas and underserved groups, such as people who are deaf and hard of hearing. Responsible parties include: University of Maryland - Department of Psychiatry MHA and Mid-Shore CSA. This initiative will enhance the number of sites utilizing telemedicine to increase access to services. Financing strategies include eventual Medicaid reimbursement. Once telemedicine equipment is installed at Springfield Hospital's Deaf unit, services will begin for this site. The TeleMental Health Alliance continues to convene on a quarterly basis.

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Additionally, the Mental Hygiene Administration, the Johns Hopkins University (JHU), and the University of Maryland (UMD) have partnered to develop the Maryland Youth Practice Improvement Committee for Mental Health (MYPIC) to provide video advice to improve mental health care for youth. Video conferencing technology has greatly improved the level of communication among providers. Seven different sites from across the state were able to participate and discuss, in real time, the latest advances regarding medication and treatment. The sites included the Johns Hopkins University, the University of Maryland, Spring Grove Hospital Center, Finan Hospital Center, and the two Regional Institutes for Children and Adolescents. Teleconferences began and continue to be held monthly, facilitated by the Directors of the UMD and the JHU Divisions of Child and Adolescent Psychiatry. **[NFC 3, 6]**

Sheppard Pratt Hospital Systems was awarded a grant from the U.S. Department of Agriculture (USDA) several years ago to install and furnish telemedicine equipment at several public and private mental health facilities in the State to improve access to care, using IP lines to provide real-time interactions between psychiatrists and patients. Three units were set up in Worcester County in conjunction with the grant. Worcester County Health Department Core Service Agency, with funding from the Mental Hygiene Administration, contracted with Sheppard Pratt to provide telepsychiatry services to clients who were homeless with mental illnesses and substance abuse problems. The Worcester County Health Department Core Service Agency has since expanded on these services by funding mental health treatment to children and adolescents. Sheppard Pratt was also awarded a grant by the Health Resources Services Administration (HRSA) to purchase equipment, train providers, and establish a telepsychiatry disaster network at several general hospitals and community mental health clinics in Maryland.

Sheppard Pratt has completed a telepsychiatry inpatient attending physician demonstration project, one of the first in the country, with a general hospital on the Eastern Shore. The general hospital was in need of psychiatric coverage during a time of staff turnover, a common problem for rural general hospitals in Maryland; as well as most other states. The hospital funded the professional fees portion of the pilot project as a demonstration of inpatient telepsychiatry utilization. Finally, a twice-monthly mental health grand rounds professional education program is provided via interactive video-conferencing to a number of hospitals and mental health clinics in Maryland. Additionally, in FY 2010, Sheppard Pratt began providing telemedicine services to children and adolescents at the Behavioral Health Clinic, an outpatient facility in Wicomico County.

Correctional Mental Health Services began utilizing telepsychiatry in 2004 at the St. Mary's' County Detention Center as part of a comprehensive program to provide mental health services to incarcerated individuals. This program currently provides telepsychiatry services at the St. Mary's, Charles, and Wicomico County Detention Centers. Through this program, both live and telepsychiatry services are provided to all sites which utilize telepsychiatry.

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MHA, in collaboration with CSAs, is now working to develop parameters for telemedicine, including its use to address access issues for remote locations, specialty services, and special needs groups. The Maryland Association of Core Service Agencies (MACSA) applied for grants, (USDA and HRSA) to obtain funding for the purchase of equipment and has partnered in this grantsmanship effort with the Mental Hygiene Administration and the University of Maryland Department of Psychiatry. In May 2008 HRSA approved the grant for telemental health equipment in rural areas. The grant is for three years with a two-year renewal possibility. The University of Maryland Department of Psychiatry has 90 psychiatrists, many board certified, who will implement the telemental health project with Medical Assistance (MA) patients from these rural areas. MHA is providing funding for the psychiatrists services which will eventually be reimbursed by MA. Telemental health has been piloted in 26 other states. Additionally, in FY 2011, Cecil County CSA will begin implementation of telepsychiatry, supported through block grant funding. **[NFC 6]**

MHA partnered with the University of Maryland's Department of Psychiatry to submit a grant application on March 6, 2009, for the federal Health Resources and Services Administration (HRSA) funding in order to develop a Center of Excellence on Telemental health for Special Need Populations. The Center of Excellence on Telemental Health will improve access to culturally competent services for the deaf and hard of hearing population. In rural communities, MHA's Office of Special Needs Populations in collaboration with Mid-Shore Mental Health Systems and Gallaudet University, has promoted a series of trainings, as well as explored the use of the Web to increase cultural awareness and sensitivity to the needs of individuals who are deaf or hard of hearing. This includes application of new communication and technology, i.e. video phone, telepsychiatry, and Web-based training.

Available Services

At present, the range of mental health and support services in rural counties is similar to those that are available in urban and suburban jurisdictions. Some services in contiguous counties are provided by programs that provide services at multiple sites throughout the area served. Mental health providers in rural areas have a history of cooperation and coordination as well as a history of sharing resources, with each other and with other service related agencies, to address the service needs of specific populations. Through this cooperation, providers have developed innovative services that are tailored to the unique needs of their areas. **[NFC 3]**

The maintenance of effective core service agencies (CSAs) is a key statewide strategy to meet rural needs. The Mid-Shore Mental Health Systems, Inc. (MSMHS) is the CSA responsible for public mental health services in Caroline, Dorchester, Kent, Queen Anne's, and Talbot counties, located on Maryland's Eastern Shore. MSMHS is currently the only regional CSA in Maryland. Of these five MSMHS counties, Queen Anne's County with a population of 47,091 was added to the Baltimore-Washington metropolitan region after the 2000 Census and is no longer considered a rural county.

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In its Community Mental Health Fiscal Year 2010 Plan Update and the FY 2011 Plan Update, MSMHS discussed the rural nature of counties in the region. Population per square mile ranges from 55.4 persons per square mile in Dorchester County to 130.1 per square mile in Talbot County, with a regional average of 89.9. The Plan emphasizes that in “planning processes to improve the system of care to assure consumer focus and one (system) that is recovery oriented, it is apparent that the unique needs of the rural jurisdictions must be given a priority.” “In the absence of a number of valuable mental health services that are difficult to replicate in rural communities, the CSA uses the spirit of cooperation to break down barriers to access and choice whenever possible”.

The MSMHS reported special initiatives and collaborative efforts targeted towards specific populations which include individuals with mental illnesses who are homeless, dually-diagnosed (mental illness and developmental disabilities), have co-occurring disorders (mental illness and a substance addiction), are deaf or hard of hearing, returning military veterans, transition-age youth and individuals whose mental health needs are coupled with a forensic background.

In FY 2010 and the FY 2011 Plan Update, the MSMHS reported on the following accomplishments:

- MSMHS partner with the consumer council to develop peer-support programming in each county and to promote efforts to become certified in the Copeland WRAP mode. MSMHS worked with a consultant to facilitate the development of a new peer support organization to serve the Mid-Shore region. A contract with Chesapeake Voyagers Wellness and Recovery Center was initiated. In July 2009, the new center opened the doors to the main location in Easton, MD and has built a strong base of membership serving 114 consumers in the first year.
- Forensic Mental Health Coordinator: MSMHS has partnered with the Circuit and District Court judges to create two regional positions that will offer the criminal justice system in each jurisdiction an opportunity to provide consumers with mental illnesses voluntary, community-based assessment and treatment alternatives to traditional methods of criminal behavior punishment through: 1) access to a licensed mental health professional who understands systems management and resources in the region and can recommend and monitor those alternatives which improve outcomes to people historically poorly-served by detention centers, 2) Monitoring of offenders in court ordered evaluation, 3) recommendations regarding community-based treatment, and 4) facilitation of ongoing communication and collaboration where criminal justice, mental health, substance abuse, and related systems intersect. (This new initiative is supported by a reallocation of community mental health block grant resources. Success will be measured by the program’s ability to lead individuals to effective community treatment and break the cycle of recidivism in the courts and detention facilities.)

In July 2009 a new Forensic Case Manager was hired to assist with diversion planning, case management services, and tracking mental health treatment and resources connections. In the first quarter of FY 2010, 36 new referrals were received for services

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and 12 consumers were still being served as carryover from the previous fiscal year. At the close of the 1st quarter, a total of 48 unduplicated consumers had received services. The goal of this program is to reduce the recidivism rate of those defendants, with mental illness, in the court system by providing linkage to mental health treatment and case management.

- MSMHS has taken the role of the lead agency for the HUD Continuum of Care (COC), and was successful in the development of 35 Shelter Plus Care permanent housing units, 17 permanent supportive housing units, and a regional Homeless Management Information System. Increased availability of affordable housing/homeless shelters was one of three prioritized regional needs identified by stakeholders. The COC has engaged three faith-based groups that have volunteered to operate shelters in the region. [NFC 3]
- MSMHS and its providers promote a long-term recovery model for consumers with serious mental illness (SMI) and have developed outcome measures for PMHS community based services. MSMHS collaborated with local providers to develop outcome measures for contractually funded services, as well as for selected services within the fee-for-service system, including adult psychiatric rehabilitation programs, residential rehabilitation programs, and supported employment.
- MSMHS continues to participate on the Governor's Office of Deaf and Hard of Hearing Mental Health sub-committee, supporting the development of a statewide needs assessment and inventory of mental health services available to individuals who are deaf or hard of hearing and will develop a state proposal to include recruitment and training of culturally competent mental health professionals. Many representatives are active on the local and state mental health advisory council. Recruitment of licensed mental health professionals proficient in American Sign Language remains a challenge, and the provision of care for Deaf and Hard of Hearing consumers continues through the use of interpreters. MSMHS contracted for a training series in partnership with MHA and Gallaudet University Department of Social Work entitled "Culturally Competent Practice for Person Who are Deaf and Hard of Hearing." Webcasts from each session in the series are available on the GUDSW website for three years and are fully ADA compliant and accessible with closed captioning.
- The closure of Upper Shore Community Mental Health Center has produced an opportunity for the expansion of the continuum of community-based care across the entire Eastern Shore. Additional resources to be added to the continuum before the end of FY 2010 include an Eastern Shore Operations Center, mobile crisis teams, crisis beds, same day outpatient appointments, mobile treatment teams (To become Assertive Community Treatment Teams), residential rehabilitation program for co-occurring disorders population, and supported-employment – evidence based practice.

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After several years of moderate expansion, Somerset County CSA (SCCSA) has worked to maintain the array and number of services available. As the second smallest county in the state, Somerset County's population actually increased slightly by 242 individuals after a decline in the previous year, according to the July 1, 2007 DHMH Vital Statistics estimates. Somerset County has only seen a 5.6% growth in population in the past 10 years, with little of that growth in recent years, and has one of the lowest median income rates in the state. These factors make it important to avoid duplication of effort and to acknowledge the need for collaboration with both in-county and tri-county (Somerset, Worcester, and Wicomico) stakeholders on planning, service expansion, and coordination of activities and efforts. The Tri-County Provider Forum continues to meet to discuss issues regarding the PMHS and to increase provider knowledge.

The state budget constraints of the past year had a significant impact on the Lower Eastern Shore Core Service Agencies. FY 2010 saw cuts of \$87,011 for Wicomico and Somerset CSA's, on top of the 5% overall reductions that had already been implemented. As a result of these and projected future budget reductions in FY 2011, Somerset CSA was unable to sustain the staffing and services necessary to maintain a freestanding CSA. In October, 2009, the two agencies merged into one operation identified as the Wicomico Somerset Regional Core Service Agency or WSRCSA.

The partnership of Eastern Shore Core Service Agencies has been integral to the success in serving the Wicomico-Somerset region. The newly developed Community Alternatives Framework (CAF) is one such example of the good work that comes from cross jurisdictional efforts. As a result of the closure of the Upper Shore State Hospital Center, WSRCSA worked with Mid-Shore CSA in planning and implementation efforts to ensure consumers and families will have alternative services available to them. The expanded services array will include: 24/7 Eastern Shore Telephone Operations Center, limited mobile crisis response services, a newly expanded urgent psychiatric evaluation service, assertive community treatment team, additional crisis bed service and more.

In the Wicomico Somerset Regional Core Service Agency Annual Plan Update for FY 2010-2011 and the original FY 2010-FY2011 Plan, the Somerset County Core Service Agency reported on the following accomplishments:

- WSRCSA continue to support MHA in identifying new and innovative ways to effectively manage the small pool of state only funds allocated for individuals who are uninsured that need services from the PMHS. Staff work diligently to help uninsured consumers access the various coverage options that they may be eligible for through the State such as the PAC (Primary Ambulatory Care) program, Medical Assistance for Families, and the Employed Individuals with Disability (DID) program.
- Collaborated with Department of Human Resources to implement regional mental health mobile crises and stabilization services to Department of Social Services (DSS) foster care involved youth and families in the three lower counties of Somerset, Wicomico, and Worcester.

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- Partnered with the Family Services Division of the Circuit Court to update and re-distribute the county resource guide;
- Support increased participation in Lower Shore Friends developing plans to implement the Wellness and Recovery Action Plan (WRAP);
- Participated in the statewide effort to launch a mental health and human services Website called Network of Care (NOC) to assist individuals, families, and agencies concerned with behavioral health;
- Continued working in partnership with the other CSAs on the lower shore and received a HUD grant to provide housing in the tri-county region to address permanent housing; and
- Partnered with Seton Center, a local affiliate of Catholic Charities, to provide mental health educational information in the Spanish. **[NFC 3]**

The Fiscal Year 2010-11 Plan and FY 2011 Plan Update for the Garrett County Core Service Agency (GCCSA) included recent accomplishments. Highlights included:

- The Garrett County Core Service Agency is planning to continue operating as a single county CSA during FY 2011 despite budget reductions. In order to maintain its operation, CSA staff have taken reduced time and worked part time with other health department programs.
- There were 28 youth served through Telemedicine services in the Garrett County Behavioral Health Center. Services have been rated very high. The Transitional Age Youth TAY program continued as TAY graduates who with youth from two local high schools. Not only does the program provide non-traditional intervention strategies for youth, but also demonstrates positive relationship between Garrett County College, Garrett County Board of Education and the GCCSA.
- Extensive collaboration and partnerships to improve services to children, youth, and adults in areas related to school mental health, peer support, addictions services, trauma and jail services, suicide prevention, and disaster planning.
- A statewide initiative for service coordination for veterans began in FY 2009. Two outpatient mental health programs in Garrett County have participated and the Western Region Resources Coordinator presented information to the community on the program at the Local Mental Health Advisory Committee (LMHAC) meeting.
- Services to Older Adults are important to maintain access to care in aging rural communities. Geriatric Mental Health Workgroup meets on a regular basis, planned depression screening at senior centers and continues with geriatric outreach. The Older Adults Transition Service (OATS) social worker continued to provide outreach, support and training for volunteers. This mental health professional links older adults to community services and provides consultation to nursing home staff, assisted living providers, and adult medical day service providers on mental health issues. **[NFC 4]**
- GCCSA continued the Adventure Sports Institute (ASI) of Garrett College, which operates the Transition-Age Youth (TAY) project. TAY graduates now act as mentors to incoming TAY participants. The Garrett County Commissioners and

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Garrett College have agreed to provide support for the third year of this successful project.

- Garrett County Sunrise Support Group for Survivors of Suicide will continue to meet with the GCCSA providing assistance and public awareness activities
- The Federally Qualified Health Center (FQHC) provided access to primary health care services on property adjacent to the Garrett County Health Department. There was a 5.6 % increase for persons served in the outpatient mental health clinic (OMHC) from 2008 to 2009. The plan notes that part of the OMHC increases resulted from more children 6-12 (one of the identified targeted population) being served.
- Closure of the Garrett County residential crisis services, Safe Harbor, contributed to an increase in inpatient expenditures for individuals utilizing the local emergency room with more complex problems requiring inpatient hospital stays.

The following table provides an overview of the six rural counties and the major programs available. Not included in the table is the broad array of individual providers in these rural communities.

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CONTINUUM OF MENTAL HEALTH SERVICES	Mid-Shore Mental Health Systems	Somerset County CSA	Garrett County CSA
Advocacy- Adult and Child	X	X	X
Community Support Funds(pharmacy, lab, transportation, other needs)	X	X	X
Detention-Based Mental Health Services	X	X	X
Inpatient Services Adult Adolescents Child	X X X	X (youth and family services in Crisfield)	Emergency Room only
Intensive Outpatient Services	X		X
Intensive In-Home Services	X	X	X
Outpatient Mental Health Adult Child and Adolescent	X X	X X	X X
Peer Support Services	X	X	X
Psychiatric Rehabilitation Program Adult Child and Adolescent	X X	X X	X X
Respite Care Adult Child	X X	X X	X
Supported Employment Services	X	X	X
Transition Age Youth Programs	X	Go-Getters provided six residential slots	X
Targeted Case Management Adult Child and Adolescent	X X	X X	X

Service Needs

In order to best assess local service needs and implement services to meet those needs, MHA strongly supported the development of CSAs in rural counties. As noted previously, all rural counties in Maryland are served by CSAs. The rural CSAs are challenged to plan, both independently and collectively, for their residents' needs and the most efficacious use of resources. All CSAs are required to include a description of their needs assessment process and findings, including gaps in services, in their local mental health planning documents. The consistent and recurring service needs identified are: adequate number and mix of providers, need for specialty service providers, transportation, crisis treatment services, and efforts to address the needs of individuals with co-occurring disorders.

One of the major challenges for a rural area is the recruitment, retention, and ongoing training of mental health professionals. The number of qualified professionals in the Mid-Shore area has increased over time and this may be attributed to the growing nature of some of the Mid-Shore counties. Conversely, in its FY 2009 Plan Update, the Garrett County Core Service Agency reports that there is only 1.6 full-time equivalent of psychiatrist time available in the county. The need for psychiatric care for the child and adolescent population is acute. Garrett County and Kent County (as well as a number of very urban census tracts in Baltimore City with special needs related to the homeless population) are designated by the federal Department of Health and Human Services, Bureau of Primary Health Care as mental health professional shortage areas (MHPSA). MHPSA designation may provide needed assistance in the recruitment of physicians.

In FY 2010-11 Plan, the Somerset County Core Service Agency identifies the development of services in rural areas as presenting multiple challenges. Accessing services is difficult, especially with limited transportation services. Available resources are scarce compared to urban areas. There are severe shortages of specialized mental health professionals and providers. Additionally, stigma continues to be an issue.

Like many rural areas, Somerset County providers are having problems attracting and keeping behavioral health professionals, particularly psychiatrists and therapists. Additionally, psychiatrist availability can be limited. One clinic in Somerset County closed new intakes for approximately one year due to having limited psychiatrist time. In the Wicomico Somerset Regional Core Service Agency Annual Plan Update for FY 2010-2011 and the original FY 2010-2011 Plan, the Somerset County Core Service Agency identified the following areas of need to continue to address:

- Maintaining collaborative initiatives locally, regionally and statewide;
- Increasing awareness and public knowledge about mental illness and mental health resources;
- The need for Independent Living Program for Transitional Aged Youth;
- Workforce education, supported employment, and or/vocational training;
- Developing strategies that address ending chronic homelessness among individuals with mental illnesses;

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- Addressing the need for integrated services for individuals with mental illnesses, substance abuse, and developmental delays; and
- Developing and implementing outcomes management objectives for all contractual obligations.

CSAs, in both rural Western Maryland and rural Eastern Shore, have identified the need to travel to adjacent counties for some services as a significant rural issue. Transportation to and from services has been a barrier not only for appointments but for consumers attempting employment and increasing involvement in their local communities. Due to the lower population density and greater distances to all types of services, rural mental health programs have acquired and operate vehicles to link individuals to services, both through mobile services and by transporting consumers to needed services. Local health departments and community action agencies also provide some publicly-supported transportation in rural counties. Additionally, CSAs have some funding in their budgets for transportation services for eligible individuals. Stigma also plays a significant role as a barrier to accessing mental health services, particularly in rural settings. The CSAs on the Eastern Shore and Lower Shore Counties work collaboratively with stakeholders to address stigma through workshops and public awareness activities.

In Mid-Shore Mental Health Systems, Inc.'s (MSMHS's) Community Mental Health Plan for Fiscal Year 2009 and 2010, a good discussion is provided of the local needs assessment process and results. The Plan discusses disproportionate representation of ethnic groups in the lower income range and the impact of the search for affordable housing as suburban counties see rapid increases in housing costs. In a chart designed to show the Mid-Shore region's continuum of care for public mental health, clear gaps in crisis services are shown. (A same day appointment service has been successfully used as a stop-gap measure.) Also the plan identifies another critical gap with regard to jail mental health delivery in the region's detention centers.

MSMHS, in collaboration with other community programs, recognizes the need for mental health services for Hispanic consumers that are uninsured. The Mid-Shore Council on Family Violence has two bilingual client advocates. For All Seasons, an OMHC, applied for a grant to obtain funding for a bilingual interpreter and MSMHS will provide the cost of the therapist, and limited psychiatrist time. [NFC 3]

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The Garrett County Core Serve Agency's (GCCSA's) 2010-2011 Mental Health Plan focuses on solidifying and enhancing existing programs. Efforts will focus on:

- Coordination and collaboration with consumers, family members, providers and other county and state stakeholders to assure accessibility to quality mental health services;
- Implementation of Telepsychiatry services at the Garrett County Community Mental Health Center to improve consumer access to skilled mental health professionals. Telepsychiatry continues to be a service well utilized by approximately 25 youth and has helped increase availability of access to child psychiatric service which has long been identified as a need in Garrett County;
- Strengthening the consumer-run center and fostering a more cohesive consumer movement for quality-based mental health services;
- Expansion of geriatric mental health services;
- Development of a continuum of community- based housing services for individuals who have severe mental illness;
- Continuation of suicide prevention activities;
- Ongoing development of services for the co-occurring population;
- Identification of funds and programs which are targeted to increasing evidence-based practices mental health services for children and adolescents and their families;
- More supported employment opportunities/work sites for those individuals who want to work;
- Increased availability of child psychiatry services- the health department hired a part-time psychiatrist leading to a decrease in the wait time for initial medication evaluation appointments for new mental health consumers; and
- Continued availability of outpatient and psychiatric rehabilitation program providers.

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SFY 2011 OBJECTIVES FOR CRITERION 4:

SERVICES FOR CHILDREN AND ADOLESCENTS

TARGETED SERVICES FOR RURAL POPULATIONS

- Explore efforts to enhance communication and education through use of social media tools and networks.
MHA Monitor: Susan Bradley, MHA Office of Management Information Systems and Data Analysis
- Collaborate with the Maryland Advisory Council for the Deaf and Hard of Hearing, the Governor's Office of Deaf and Hard of Hearing (ODHH), CSAs, advocates, and other involved parties to implement standards identified by DHMH to enhance access to services that are culturally competent, clinically appropriate, and recovery-oriented for individuals who are deaf or hard of hearing.
MHA Monitor: Marian Bland, MHA Office of Special Needs Population
- Enhance PMHS data collection and monitoring through continued activities to develop and/or refine management information systems.
MHA Monitor: Susan Bradley, MHA Office of Management Information Systems and Data Analysis
- MHA will work in conjunction with Department of Human Resources (DHR), Care Management Entities (CMEs), and other stakeholders to improve screening, assessment, and service delivery for children and youth in foster care.
MHA Monitor: Al Zachik and Cyntrice Bellamy, MHA Office of Child and Adolescent Services

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CHILDRENS PLAN CRITERION #4

TARGETED SERVICES TO THE HOMELESS

The exact number of children and youth in Maryland who are homeless and who have mental health problems is unknown. MHA has been participating in the efforts of the Maryland Department of Human Resources (DHR) and local communities to implement the Homeless Management Information System statewide. All of the Maryland counties have established a system and most of the counties have trained shelters' staff and providers on utilizing the Homeless Management Information System. Some counties are still working to resolve issues regarding providers' resistance to using the Homeless Management Information System due to concerns about client confidentiality. Data are not broken out by age as a part of the survey. Efforts are also underway to develop a statewide data warehouse so that local homeless data may be accessed at the state level. **[NFC 6]**

DHR gathers and reports information only on people who have stayed in emergency shelters, transitional housing programs or who have received emergency motel placements. The data reflects the extent of shelter services provided to people who are homeless as reported by emergency shelter and transitional housing providers on a Homelessness Services Survey form. The data in DHR's report does not include an absolute count of the number of homeless people in Maryland.

According to DHR's FY 2008 Annual Homeless Report, there were 37,955 persons served in Maryland's homeless shelters. This is a 3.5% increase from FY 2007 in which 36,599 persons were in shelters. There were 27,469 people served in emergency shelters, 5,910 served in transitional housing, and 4,576 served through motel placements. Of this amount, it is estimated that there are 9,492 homeless sheltered persons who have a mental illness in Maryland. It is estimated that there were about 3,176 non-sheltered homeless people in Maryland in 2007, using the National Alliance to End Homelessness estimates of the unsheltered homeless.

SSI/SSDI Outreach, Access, and Recovery (SOAR). Individuals who are homeless can benefit from Medicaid enrollment to obtain needed services. The purpose of SOAR is to expedite and increase the number of successful SSI/SSDI applications for all eligible applicants. In FY 2010, MHA re-launched and expanded the pilot initiative in Baltimore City and Prince George's County, and allocated funding for two SOAR Outreach specialist. MHA also funded a part-time Data and Evaluation Consultant position.

During FY 2010, over 50 applications have been submitted within Maryland using the SOAR process. The overall approval rate for Maryland is over 90%. Baltimore City, which has submitted the most applications, has a 100% approval rate for new applications. The initiative has seen significant growth in recent months. The following areas have active working groups: Baltimore City, Anne Arundel, Howard, Montgomery, Prince George's, and the Lower Eastern Shore counties (Somerset,

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Wicomico, and Worcester). Five 2-day trainings were held in FY 2010, training over 150 case managers, mental health professionals, and social workers.

In FY 2011, MHA has obtained additional PATH funding for two more SOAR outreach positions. It is anticipated that the focus in FY 2011 will be on those counties that are currently implementing SOAR, or who have already actively begun the planning process.

Services for Runaway and Homeless Youth. The unmet needs of youth that are homeless are extensive, particularly the needs of the runaway and homeless adolescents with serious emotional disturbance. A special project, for runaway and homeless youth, continues in Ocean City, Maryland, the state's major beach resort area. Located in Worcester County on the Eastern Shore, Ocean City increases from a relatively small community to a population of close to 400,000 in the summer. Many runaway and homeless youth frequent the resort, some experiencing serious psychiatric disorders, almost all involved, in some way, in drug and alcohol abuse. The agencies in the community have formed a successful collaborative consortium to coordinate shelter, primary health, substance abuse, mental health, and other human services for this population. The project serves youth from all areas of the rest of the Maryland and large numbers of youth from other surrounding states in the region. Federal community mental health block grant funds have been allocated for mobile crisis services in Worcester County. This project is intensively staffed. [NFC 5]

Services for Children in Homeless Families. MHA has funded and provided technical assistance to a project for young children who are homeless because their mothers and other family members live in family shelters throughout Baltimore City. The Parents and Children Together (PACT) program provides a therapeutic nursery at the YWCA shelter in Baltimore City, and extensive consultation at The Ark, a day care program that serves many of the children who reside in family shelters across the entire city. This population is reported to experience significant developmental delays, particularly in language acquisition.

Children and adolescents with serious emotional disturbance in families that are homeless can access Maryland's Projects for Assistance in Transition from Homelessness (PATH) and Shelter Plus Care programs for services. PATH funds are used for outreach, engagement, case management, screening and diagnostic services, consultation to shelters, training, housing assistance, supportive services in residential settings, and mental health and substance abuse services. PATH funded case managers are located in shelters, detention centers, and service agencies, facilitating outreach and access to services in a timely manner. PATH provides outreach and access in urban, suburban, and all rural areas in Maryland. These services also link individuals and families to the fee-for-service system. The PATH Program is targeted to homeless consumers who have serious mental illnesses or co-occurring substance use disorders, who are disconnected from the community and lack the necessary supports to obtain permanent housing.

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The PATH program provided services in 23 counties and Baltimore City in FY 2010. In SFY 2009, the funding level was \$1,172,000. Local PATH supported agencies identified 3,632 homeless individuals with mental illnesses. Of these, 1,949 actually enrolled for PATH services. In FY 2010, PATH was increased by \$140,000 which funded SOAR Outreach Specialists in Baltimore City and Prince George's County and a Data and Evaluation Consultant. In FY 2011, PATH was increased by another \$115,000. In FY 2011, PATH will be funded at \$1,287,000, and is projected to enroll an estimated 2,402 individuals and families. The following table presents a summary of the most current PATH program information:

SERVICE AREA OF PROJECT	ADMINISTRATIVE ENTITY	PATH SFY 2011 FUNDING	PROJ. # SERVD. SFY 2011	SERVICES PROVIDED UNDER PATH
Allegany County	Allegany County Mental Health Systems	\$54,955	40	ALLEGANY COUNTY MENTAL HEALTH SYSTEMS - Community outreach, case management, staff training, housing assistance, supportive services, referrals to primary health services, job training, educational and relevant housing.
Anne Arundel	Anne Arundel County Mental Health Agency	\$48,100	80	Anne Arundel County Mental Health Agency –PATH/SOAR assistance with SSI/SSDI, linkage to community mental health resources, case management, outreach to homeless, emergency shelter and transportation arrangements, linkage to intensive outpatient treatment and transitional housing.
Baltimore City	BMHS Baltimore Mental Health Systems, Inc.	\$335,756	355	BALTIMORE MENTAL HEALTH SYSTEMS BMHS to provide technical assistance in locating and developing affordable housing, room and board training, registry of house resources.
				UNIVERSITY OF MARYLAND MEDICAL SYSTEMS- SSI outreach, linkage to services and housing, case management, liaison to homeless outreach teams, outreach assessment.

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SERVICE AREA OF PROJECT	ADMINISTRATIVE ENTITY	PATH SFY 2011 FUNDING	PROJ. # SERVD. SFY 2011	SERVICES PROVIDED UNDER PATH
				<p>HEALTH CARE FOR THE HOMELESS-Street outreach, SSI Presumptive Eligibility Project, mental health and addictions treatment, and case management. SOAR Outreach Specialist to develop and maintain relationships necessary to achieve more rapid SSI/SSDI application approvals, including relationships with SOAR partners, Disability Determination Services, Social Security Administration, Policy Research Associates, Mental Hygiene Administration and others. Provide technical assistance to case managers and other SOAR trained providers with outreach to homeless individuals and completing SSI/SSDI applications for benefits.</p>
				<p>PRISONER'S AID ASSOCIATION- Outreach, case management, linking women who have a history of mental illness and trauma to services and housing</p>
				<p>CHRYSLIS HOUSE HEALTHY START PROGRAM - 16 bed diagnostic and transitional facility for pregnant and post-partum women and their babies. The participants will be women who are incarcerated in local detention centers and have misdemeanor charges. Comprehensive assessment, outreach assessment, housing assistance, case management, access to appropriate treatment resources and services will be provided.</p>
				<p>STATEWIDE TRAINING – 2 day SOAR trainings and 1-day refresher training, workshops on homelessness at Special Populations one-day conference.</p>

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SERVICE AREA OF PROJECT	ADMINISTRATIVE ENTITY	PATH SFY 2011 FUNDING	PROJ. # SERVD. SFY 2011	SERVICES PROVIDED UNDER PATH
Baltimore County	Dept. of Health Bureau of Mental Health CSA	\$96,200	150	PROLOGUE, INC. – Outreach, screening and diagnostic services, training, case management, housing coordination and matching, security deposits, one-time rentals (eviction prevention), support and supervision in residential settings, staff training.
Calvert County	Calvert County CSA	\$30,380	124	CALVERT COUNTY MENTAL HEALTH CLINIC Outreach, screening, case management relevant housing services, referrals for primary health, community mental health services, substance abuse treatment, job training programs, educational services.
Carroll County	Carroll County CSA	\$37,000	50	KEYSTONE SERV.OF MD – Outreach, intensive case management, screening and diagnostic treatment, assistance with linking to housing and services linking to training, support in residential settings.
Cecil County	Cecil Co CSA	\$5,000	8	CECIL COUNTY CORE SERVICE AGENCY -One time only rental assistance, security deposits and training, contract with outreach and case management services.
Charles County	Charles County CSA	\$35,000	75	SOUTHERN MARYLAND DIVISION OF CATHOLIC COMMUNITY SERVICES – Outreach, referral to intensive case management, mental health services, linkage to mental health services, screening and diagnostic treatment, assistance in planning for housing, technical assistance with housing, referrals to alcohol and drug treatment, medical care, pharmacy assistance, job training, educational legal assistance, and assistance with security deposits.

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SERVICE AREA OF PROJECT	ADMINISTRATIVE ENTITY	PATH SFY 2011 FUNDING	PROJ. # SERVD. SFY 2011	SERVICES PROVIDED UNDER PATH
Frederick County	Frederick County CSA	\$77,400	300	FREDERICK COMMUNITY ACTION AGENCY – Outreach, case management, referrals for health care, job training, alcohol and substance abuse treatment, transportation, housing coordination, supportive and supervisory services, and the development of Med bank services to link PATH clients to free prescription medications made available through patient assistance programs.
Garrett County	Garrett County CSA.	\$24,500	29	GARRETT COUNTY CSA. - Screening, housing coordination, security deposits, one - time only rental assistance linkage to permanent housing, and referrals for mental health and other services.
Harford County	Harford Co CSA	\$71,524	95	CORE SERVICE AGENCY IN COLLABORATION WITH ALLIANCE, INC. – Outreach, case management, linkage to housing, assessments, and referrals, substance abuse and assertive treatment services, services to prevent re-incarceration and improve access to services upon release from incarceration.
Howard County	Howard County CSA	\$35,478	25	GRASS ROOTS CRISIS INTERVENTION CENTER – Case management, psychiatric services, referral, housing assistance, assistance with entitlements.
Mid-Shore (Caroline, Dorchester, Kent, Queen Anne's, and Talbot Counties)	Mid-Shore Mental Health Systems, Inc.	\$52,624	80	MIDSHORE MENTAL HEALTH SYSTEMS, INC. – Contracts with vendors to provide homeless outreach to all five counties, assessments, housing security deposits assistance, case management, conduct needs assessment, one time only rental payments.

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SERVICE AREA OF PROJECT	ADMINISTRATIVE ENTITY	PATH SFY 2011 FUNDING	PROJ. # SERVD. SFY 2011	SERVICES PROVIDED UNDER PATH
Montgomery County	Montgomery County CSA	\$115,588	300	MONTGOMERY COUNTY DETENTION CENTER- Outreach, engagement, linkage to mental health and co-occurring treatment services, case management, and housing assistance.
				VOLUNTEERS OF AMERICA- Outreach on streets, at emergency shelters, day programs, soup kitchens and to those on the psychiatric crisis intervention unit, case management and linkages to entitlements and services.
Prince George's County	Department of Family Services, Mental Health Authority Division	\$119,264	140	QUALITY CARE INTERNET BEHAVIORAL HEALTH – Outreach, screening, assessment, case management, supportive services in residential settings, housing assistance, referrals to mental health services, medical, housing, rehabilitation, and vocational training, one time only rental assistance and security deposits. Prince George's County Department of Social Services or selected vendor will target Thirty (30) individuals and assist them with completing SSI/SSDI applications based on technical assistance and training provided by SOAR Outreach Specialist.
Somerset County	Somerset County CSA	\$10,000	6	SOMERSET COUNTY CORE SERVICE AGENCY-Outreach, housing services, i.e. one time only rental assistance to prevent eviction, security deposits, planning of housing, and minor renovations to existing housing.
St. Mary's County	St. Mary's Department of Human Services	\$45,950	120	DETENTION CENTER MENTAL HEALTH - to serve homeless, detention center inmates with mental illness, screening, assessment, linkage to community resources. Two hours per week of telepsychiatry in a mental health clinic to assist with aftercare planning.
				THREE OAKS SHELTER – Outreach and case management services and aftercare which includes housing are its goals.

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SERVICE AREA OF PROJECT	ADMINISTRATIVE ENTITY	PATH SFY 2011 FUNDING	PROJ. # SERVD. SFY 2011	SERVICES PROVIDED UNDER PATH
Washington County	Washington County CSA	\$37,000	350	TURNING POINT – Case management outreach, job training, supportive and supervisory services, screening and diagnostic services. 2 positions: homeless outreach worker and outreach assistance.
Wicomico County	Wicomico County CSA	\$22,000	40	WICOMICO COUNTY CSA- Assessment, service planning, linkage to mental health, housing, medical, employment, outreach, and case management.
Worcester County	Worcester County CSA	\$33,281	35	HEALTH DEPARTMENT – MENTAL HEALTH PROGRAM – Mobile assessments, assertive outreach, training one - time only rental payments, security deposits, minor renovation, expansion and repair of homes, mental health and case management.
TOTAL Maryland	24 Jurisdictions	\$1,287,000	2,402	

As in previous years, data on the number of persons served included those served through outreach and those receiving ongoing PATH services. Due to changes in definition, PATH consumers who are engaged through outreach are no longer included in the number of persons to be served. PATH providers are currently counting only those who are considered enrolled (client file opened and service plan developed) as the number served in FY 2010.

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In 1995, the U.S. Department of Housing and Urban Development (HUD) first awarded MHA a five-year, \$5.5 million Shelter Plus Care grant to provide housing for individuals who are homeless with serious mental illnesses and their dependents who are being released from the detention center, or are in the community on intensive caseloads of parole and probation. Last year, the FY 2010 Shelter Plus Care Housing grant was renewed for \$3,820,578 for 22 Shelter Plus Care renewal grants.

For FY 2011, MHA was awarded funding in the total amount of \$4,529,532 for the Shelter Plus Care renewal grants. The renewal grant award was increased largely due to increases in the Fair Market Rental Values, increases in the number of units funded by HUD, and the renewal of all five-year grants. Currently, MHA is serving a total of 599 persons, 137 single individuals with mental illness, 165 families with 283 children and 14 other family members through all of the Shelter Plus Care grant programs.

Since 1995, the process for applying for funding through the U.S. Department of Housing and Urban Development (HUD) has changed. In 1996, HUD introduced communities to the Continuum of Care model to strategically address the problems of housing and homelessness in a more coordinated and comprehensive fashion. The model required local communities to develop a strategic plan to address the use of HUD resources and this also became the application process for obtaining HUD funding. As a result of this change, MHA lost its ability to directly apply for Shelter Plus Care Housing grant funds to HUD and to apply for funding using a single statewide application. The new process requires MHA and other state and local entities to apply for funding through the local Continuum of Care Planning group. In FY 2010, MHA submitted 22 renewal grants to thirteen Continuum of Care Planning groups as a part of their application for HUD funding. Each local Continuum of Care of Plan must incorporate MHA's Shelter Plus Care application into its local plan annually.

Advocates for the homeless and for housing for people with disabilities in Maryland have expressed concern with proposed changes in the Housing Choice Voucher Program. If fewer vouchers are available for individuals with disabilities, then it will be more difficult to advance consumers from Shelter Plus Care to other housing choice programs.

Individuals who are homeless are also served by traditional mental health treatment and support programs, including existing psychiatric rehabilitation programs, case management entities, crisis service providers, and mobile and on-site clinic services. In addition, outreach and eviction prevention services, as well as coordination with needed mental health services are provided to homeless individuals. In Baltimore City, Baltimore Mental Health Systems, Inc. obtained grant funds to provide case management and other services for homeless individuals with mental illnesses. State general funds and mental health block grant funds support additional services and programs for the homeless population.

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MHA provides state general funds to support statewide training for mental health providers, which includes providers of PATH services. A portion of Baltimore Mental Health Systems PATH funding is targeted for training for PATH staff delivering services to PATH eligible consumers. In addition to formal training, MHA have quarterly meetings with PATH providers to discuss clinical and programmatic issues and to provide an opportunity for information sharing between local providers.

In SFY 2010, MHA's Office of Special Needs Populations sponsored several trainings and a conference. The Office sponsored five 2-day Stepping Stones to Recovery SOAR trainings in collaboration with the University of Maryland Training Center using state general funding and PATH funding.

The 2-day SOAR trainings provided an in-depth, step by step explanation of the SSI/SSDI application and disability determination process and provided strategies for case managers working with homeless persons with serious mental illness and co-occurring substance use disorder to successfully access SSI/SSDI benefits. A total of 166 people were trained through these five 2-day trainings.

In addition to SOAR, the Office of Special Needs Populations/Behavioral Health Disaster Services (BHDS), in collaboration with the Office of Consumer Affairs, provided 3 regional disaster preparedness seminars in April 2010. The training seminars addressed, among other things, consumer questions and concerns as expressed in a recent survey to On Our Own chapters across Maryland. Each regional session was three hours in length and was designed to promote audience participation and to generate sustainable action plans for Wellness & Recovery Centers with regard to disaster preparedness, response, recovery and mitigation. Agencies who attended included Wellness and Recovery Center directors, board members and consumers, local NAMI representatives and Core Service Agency (CSA) personnel. A total of 54 individuals attended and are now able to provide local trainings to staff and consumers. These trainings were held on April 8, 2010 in the Eastern Shore region, April 12, 2010 in the Western region, and on April 21, 2010 in the Southern region.

On June 18, 2010, MHA's Office of Special Needs Populations co-sponsored the Thirteenth Annual Symposium on Mental Disability and the Law along with the Office of Forensics Services and the University of Maryland Mental Health Training Center. As a part of this symposium, training was provided for trauma specialist on the Trauma, Addictions, Mental Health, and Recovery (TAMAR) treatment model.

Another essential task which supports the trainings includes technical assistance to counties with implementing SOAR and incorporating SOAR critical components into existing PATH services. With technical assistance from the National SOAR Technical Assistance Center at Policy Research Associates, the Director of the Office of Special Needs Populations (SOAR Team Leader for MD) met with Anne Arundel County, Baltimore County, Frederick County, eight of the Eastern Shore counties which consist of: Caroline, Dorchester, Kent, Queen Anne, Somerset, Talbot, Wicomico, and

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Worcester; and Montgomery County to implement a SOAR initiative in their local jurisdictions. In November 2009, Anne Arundel County launched their SOAR initiative. In June 2010, the Lower Eastern Shore counties of Somerset, Wicomico, and Worcester launched a SOAR initiative. In September 2010, Howard and Montgomery counties' SOAR initiative will be launched.

MHA's Office of Special Needs Populations will continue to meet with other jurisdictions to expand SOAR and PATH services statewide during FY 2011. MHA's Office of Special Needs Populations will be meeting with Carroll County Core Service Agency (CSA) and several providers that serve persons who are homeless to develop a SOAR work plan and to implement the SOAR initiative in Carroll County. Finally, MHA will continue to be involved in the HUD Continuum of Care process to access funding and partner with local agencies to expand service and housing opportunities for persons who are homeless and have a mental illness.

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SFY 2011 OBJECTIVES FOR CRITERION 4:

SERVICES FOR CHILDREN AND ADULTS

TARGETED SERVICES TO THE HOMELESS

- Utilize Projects for Assistance in Transition from Homelessness (PATH) funding and the SSI/SSDI Outreach, Access, and Recovery (SOAR) Initiative mechanisms for outreach, the prevention of homelessness, and the promotion of recovery for individuals who have mental illnesses.

MHA Monitor: Marian Bland and Keenan Jones, MHA Office of Special Needs Populations

- Maximize use of the Shelter Plus Care Housing funding, and other support systems to provide rental assistance to individuals with mental illnesses who are homeless, or were formerly homeless, using federal Department of Housing and Urban Development (HUD) funding.

MHA Monitor: Marian Bland and Keenan Jones, MHA Office of Special Needs Populations

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ADULT & CHILD PLAN

CRITERION #5: Management Systems

This Criterion applies to both adult and children and adolescents. It is not duplicated in the Child Plan section.